The Canadian Nurse

Registered at Ottawa, Canada, as second class matter.

Editor and Business Manager:
MARGARET E. KERR, R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR OCTOBER, 1944

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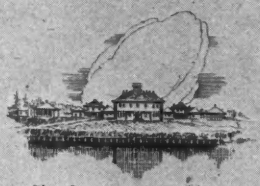
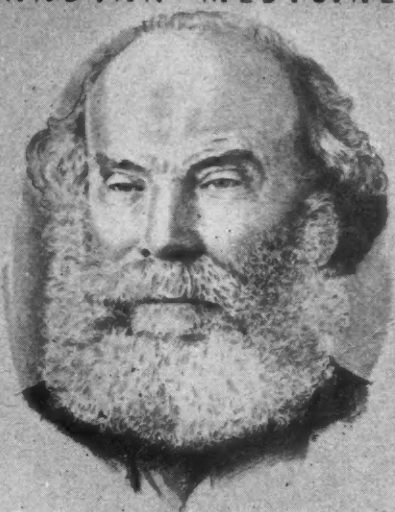
FATHERS OF CANADIAN MEDICINE

★ONE OF A SERIES



The Government Buildings, Victoria, B.C., about 1876.



Wm Fraser Tolmie PHYSICIAN AND EXPLORER (1812-1896)

ONE of the first physicians to practise his profession in the province of British Columbia was a Scotsman by the name of Wm. Fraser Tolmie. Tolmie was born in the Highlands of Scotland in 1812, studied medicine in Glasgow and received the degree of L.F. and P. and S. in 1832.

Being an adventurous character, the following year Tolmie journeyed to North America going around Cape Horn to Fort Vancouver, Ore., a journey fraught with hardship and danger during the early part of the 19th century. On arrival, he entered the employ of the Hudson's Bay Company as doctor and clerk, eventually becoming a chief factor of the company. In 1834 he was attached to an exploration expedition under Peter Skene Ogden along the north-west coast as far as the Russian boundary.

The urge to still further study the subject dear to his heart was uppermost in Tolmie's mind and in 1841 he again crossed the Atlantic to take a postgraduate course in Paris.

In 1859 Dr. Tolmie became a permanent resident of Victoria, B.C., and took a keen interest in civic and provincial affairs. He was a member of the first Victoria School Board and for two terms represented Victoria district in the Legislative Assembly.

Together with Dr. G. M. Dawson, Dr. Tolmie compiled a comparative dictionary of Indian languages in British Columbia.

Dr. Tolmie died at Cloverdale Farm, Victoria, B.C., at the age of 74, having done much to place the practice of medicine in Canada on a sound foundation. His unselfish devotion to his work of helping others inspires this company to maintain with unceasing vigilance its policy—Therapeutic Exactness and Pharmaceutical Excellence.

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Reader's Guide

Those who attended the convention in Winnipeg will recall the fine exhibit prepared by the Registered Nurses Association of the Province of Quebec under the able direction of **Miss E. Frances Upton**, executive secretary. The condensation of all of the provincial Registered Nurse Acts was a monumental piece of work and we are pleased to present it in this permanent form.

With this issue, a new feature of the *Journal* is introduced under the caption of **Interesting People**. There are so many in the field of nursing who are doing very worthwhile work and who are deserving of honourable mention that it seemed appropriate to concentrate brief notes about them under one heading. Despite all of the facilities we have for collecting items to be included on this page, there are likely to be many whom we do not hear about. We would appreciate your co-operation in forwarding authentic information to us.

From **Helen E. Penhale**, Chief of the Division of Hospital and School of Nursing Administration, University of Western Ontario, London, comes a challenge to every head nurse and floor supervisor to incorporate more teaching in the ward experience of the student nurse. Even today when every bed is taken in our hospitals, there is a continued if not an increased need to make every hour of the students' experience a learning experience.

Before she left to join the R.C.A.M.C. Nursing Service, **Eleanor C. Weir**, a registered occupational therapist, was on the staff of the Metropolitan Health Committee in Vancouver. Her extensive experience in arranging work for tuberculosis patients in their homes gives her a keen understanding of the psychological value of providing some form of activity for the convalescent patient.

Lawrence E. Ranta, M.D., D.P.H., of the Connaught Laboratories (Western Division) and Department of Bacteriology and Preventive Medicine, University of British Columbia, spent a considerable time in research work in nutrition, working under Dr. Pett. He challenges our thinking and teaching in his discussion of the utilization of vitamin concentrates. The facts regarding the claims made by advertisers of vitamin pills and capsules, coming from such an authority, will assist nurses.

Sister Paulette Fortier, the author of "The Silent Invader" and a graduate of St. Mary's School of Nursing, Montreal, spent five years as head nurse of the Fort Smith General Hospital, N.W.T., before taking a post-graduate course in surgery at the Holy Cross Hospital, Calgary. The dreadful scourge of cancer is still taking a devastating toll among all classes. Sister Fortier's earnest appeal to all nurses is to help in securing the early diagnosis and treatment of afflicted persons.

Our contribution on the General Nursing Page this month is a well-known public health nurse, **Winnifred Ashplant**, of London, Ontario. Miss Ashplant's paper was delivered at the last convention of the R.N.A.O. She makes us realize that every nurse has a role to play in promoting the nation's health.

Mrs. S. Elizabeth Heldal was serving as district nurse in a rural area in Alberta when she wrote of her experiences. The demands made upon the nurse's knowledge and skill in every facet of life is typified in her account. Truly, nurses serving on the home front meet many a challenging situation.

Our cover shows an R.C.A.F. nurse in one of the wards under canvas tending to her patient. Everywhere that the nurses go in the course of their many duties to aid our fighting men, they need supplies and equipment which we can assist in supplying through our purchase of Victory Bonds during the Seventh War Loan drive.

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The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION
VOLUME FORTY NUMBER TEN

OCTOBER, 1944

Facing Facts

An old scholar said to me recently "the way to read seriously is to fight the writer every inch of the way, to challenge his philosophy and conclusions, to make sure that his statements are true."

The reports of the biennial meeting have already appeared in the September issue of *The Canadian Nurse* to be read by many for the first time and to be re-read by those who heard them in Winnipeg. Many at the Winnipeg meeting commented on the impossibility of adequately sizing up a report when heard for the first time and expressed the hope that in future important reports, especially those containing recommendations affecting the whole future of Canadian nursing, would be in the hands of the provincial offices some weeks before the biennial meeting. They stressed the danger of accepting recommendations hurriedly even though presented by a good committee. It happens that an emphatic statement made by an emphatic person is readily accepted. Therefore these reports should now be read again, asking what facts justify the statements made, what in the present situation makes the proposals seem wise, what logic lies behind the conclusions and what will be the long term effect.

And next, study just as critically present problems which we continue to leave unsolved. There is a shortage of nurses and therefore of nursing, the latter aggravated in hospitals through nursing time being used for many things. Many hospitals which are short staffed have urged National Selective Service to freeze nurses in positions and to restrict private duty. Your liaison committee has opposed such freezing for reasons similar to those which are now being put forward by the Canadian Teachers Federation to secure the removal or modifying of the freezing applied to teachers. And we have urged the nurses' registries to further regulate the liberties of their members in a hope of avoid-

ing other control which may be forced through public opinion.

As a profession we have not realized the importance of public opinion. We do little to create either a favourable public or an informed one. How many women's or men's organizations know why nurses are both taught and trained or anything of the preparation needed for various fields of nursing? The public know that the sick must have nurses and that the Victorian Order of Nurses is doing a good job. They do not know of the many nurses who have remained on their jobs in spite of the greatest difficulties or of those who have stayed with sick patients under the most trying conditions. But they do know that even before the war more and more nurses were unwilling to do evening and night duty, to nurse in the home and out of town, and that at Christmas and New Years private duty nurses were practically not obtainable.

The needs of the Canadian people for nursing service will have to be met. If not met by nurses then the public will demand the preparation of another group. It is not enough for us to continue to talk of serving the public, we must devise some means of maintaining a continuous adequate service.

FANNY MUNROE
President
Canadian Nurses Association.

That Men May Serve

The past few months have witnessed a sharp up-swing in the demands made upon our nursing sisters serving with the armed forces. Every daily paper records long lists of casualties and if we could read the story behind the news we would know the full demand that is being met daily by our colleagues in the services for expert nursing care, for unstinting devotion to the cause they serve. Remarkable records are being established for the quick return of the men who have sustained injuries to normal living, to further service with their units. That men may serve our nursing sisters are on the job every minute of every hour of every day.

But who is to pay for all of the equipment required in the clearing stations? Who foots the bills for the miracle drugs which must be immediately available? Who is to finance the long periods of recovery which frequently occur? The answer is so easy — the government. It is an easy answer until we ask ourselves who or what is the government? It is the people of Canada of which we of the Canadian Nurses Association form a small but important part. We must help to pay the bills through our purchase of bonds in this the Seventh Victory Loan.

It is a pleasantly reassuring thought that by thus doing our part in finishing the war we are also ensuring for ourselves a measure of security in the days to come. No better means was ever provided for salting away savings against a possible lean time than through the purchase of bonds backed by the Dominion of Canada.

Be patriotic — help our beloved country by investing freely and fully in bonds of the Seventh Victory Loan.

Be prudent — help yourself to an assured independence by your liberal purchase now of the tokens of security — Victory Bonds.

Invest in Victory!

—M. E. K.

The Value of Vitamin Concentrates

LAWRENCE E. RANTA, M.D.

In dealing with the attitude of public health workers towards vitamins one might interpret it by saying that, for the public in general, vitamins are agents in the realm of preventive medicine. The public health worker believes that the public should have a three-point training in the science of nutrition in its intimate relationship to the prevention of malnutrition. These points consist of (1) judicious selection of foods, (2) efficient preparation of foods to ensure retention of essential elements of nutrition as well as of the important elements of flavour, and (3) a vigorous insistence that the food manufacturer and handler process, transport and store foodstuffs in such a manner that proper selection and preparation will not become mere gestures of gastronomic good-will. This three-point training is based upon the sole dietetic axiom: sensible marketing and preparation of varied foods should provide every normal individual with sufficient energy-producing materials, proteins, minerals and vitamins. Therefore, with the possible exception of Vitamin D for those leading indoor lives in northern climates, vitamin concentrates have no place as staples in the diet of the adult members of the public.

Fortification of foodstuffs with synthetic vitamins is of insufficient value to warrant recommendation by public health workers. Vitamins cannot now and, perhaps, can never be manufactured as cheaply as they can be produced in foodstuffs. Hence, all fortification must be relatively costly. If the addition of vitamins necessitates raising the cost of some basic food, the procedure defeats its intended purpose, simply by reducing the use of that food by those in the lower income brackets; that is, by those having the greatest need. If fortification were paid for by subsidy from public funds, the objection would not be eliminated. In this case, the cost would be borne mostly by those persons in the higher income groups; but even so, some of the extra expense must be met by those least able to pay.

Furthermore, one might suggest that fortification with specific vitamins assumes a rather complete knowledge of human nutrition. The acceptance of fortification as a guiding principle might lead to neglect of those factors about which we know little or of those as yet undiscovered. Fortification with synthetic vitamins might, therefore, prove to be an expensive nutritional boomerang; unless, of course, pains were taken to continue to educate the public to eat an adequate diet: in which case, fortification becomes a superfluous undertaking.

Fortification is directly associated with the problem of daily requirements by humans of the various vitamins. In the present state of our knowledge of human nutrition, it is unwise for us to look upon the daily allowances in the officially adopted schedule as anything more than the tentative suggestions that they are intended to be. Ever-growing evidence indicates that some of these recommended allowances exceed the real need in more or less degree; but by what excess will have to be determined by future research. The likelihood of this excessive recommendation has been suggested by results of nutrition surveys where an effort has been made to correlate food intake with physical condition. The fact that an excellent physical condition is sustained by what appears to be a deficient intake of an essential factor points a very sus-

picious finger at the standard of measurement. For example, during the years of this war, the British peoples have been maintained on an ascorbic acid intake only 2/5th of that recommended as desirable for Canadians. The generally improved health and nutritional status of the British peoples and the lack of any evidence of ascorbic acid deficiency certainly would indicate that our adopted standards incline towards vitamin over-enthusiasm.

This would imply that our much-worked talking-point, that three of every five Canadians suffer malnutrition, perhaps is not quite accurate. Let us say that it has propagandal value, but the fact itself is deeply dusted with scientific obsolescence. We should recognize this possibility lest we become victims of our misconceptions, lest we fall into the cultist's trap, believing that all, or even a majority, of man's ills arise from his faulty food habits. How considerate of Providence if it were so! This trap we must avoid as surely as we accept the facts that absolute and relative vitamin deficiencies initiate, or contribute to, some illnesses plaguing mankind and that these illnesses can be specifically alleviated by vitamin concentrates.

The popular enthusiasm for the indiscriminate use of vitamin concentrates needs not be examined here. The reason is rooted far back in the history of mankind, even beyond the recipe for a tonic inscribed some 3500 years ago in the Ebers papyrus. The reason is as substantial as the determination, on one hand, and the courage, on the other, that inflicted "sulphur 'n' molasses" on the pre-vitamin generations. The public were well prepared for vitamins. And many there were among us who watched the role of the vitamins unfold year by year and felt that here at last we were reaching the fundamentals whence spring human maladies. Consequently, as vitamin concentrates were made available, it was understandable that they should be received enthusiastically by both professional workers and laymen alike; but, now that we have passed this introductory phase, a re-evaluation is due.

Based upon the existing knowledge of nutrition, it is postulated that vitamin concentrates can be of value only under five circumstances. When any one of these circumstances exists, vitamin concentrates must be administered in large quantities and by the route that will bring ample quantities of the specific active agent to the functioning cells in the shortest time. Where an actual deficiency is present the response to treatment is usually rapid and, often, dramatic. If the response is not soon forthcoming, it is wasteful to continue the treatment; rather, a further search should be made so that reconsideration may be given to the diagnosis and, hence, to the treatment.

The five circumstances in which vitamin concentrates may be logically used will now be defined, each being illustrated by examples.

First Circumstance: If a deficiency exists in an individual owing to the habitual consumption of inadequate quantities of a vitamin, concentrates will be of value.

This circumstance covers all of the gross vitamin deficiencies, but it does not include mild border-line deficiencies which are best controlled by diets of natural foodstuffs possessing high vitamin contents. Gross vitamin deficiencies are infrequently seen in Canada except among those living in relatively isolated areas of the country. These can usually be attributed to enforced monotony of diet brought about by difficulty in obtaining supplies of foods containing the protective food factors.

Related to deficiencies caused by inadequate consumption of vitamins is that which results from alteration of the bacterial flora of the intestine. Comparatively few investigations have been con-

ducted to study synthesis and destruction of vitamins by bacteria in the human intestine. That some bacteria are capable of destroying ascorbic acid has been demonstrated and it is possible that, where the intake is at the borderline of adequacy or where the demand for the vitamin increases, this destruction can mean the difference between sufficiency and deficiency. Conversely, some bacteria normally present in the intestine possess the ability to synthesize certain vitamins, especially Vitamin K^2 and some members of the Vitamin B group. Following therapy or diseases which change the bacterial flora of the intestine the likelihood of vitamin deficiencies presents itself.

Second Circumstance: If a deficiency exists in an individual owing to some condition producing or requiring such limitation of diet that natural foodstuffs consumed cannot supply the requisite quantity of vitamins, concentrates will be of value.

This circumstance includes some deficiencies most commonly observed in infants, invalids and aged persons.

Modern infant feeding methods recognize the necessity for the early addition of certain vitamin concentrates to the diet. Especially in the formula-fed infant, cod liver oil or similar fish liver oils are added to the diet at the end of the first month. This is required not alone for its anti-rachitic properties, but also because the dilution of the milk coincidentally dilutes the Vitamin A so that the amount of formula consumed supplies inadequate quantities of this vitamin and the pre-natal stores are soon depleted.

At present, aged persons and invalids suffering from chronic systemic ailments receive the poorest dietetic treatment. The long-term diets for invalids are often so inadequate that one should not be surprised to find that invalidism, once established, tends to become a permanent state. Only through a complete revamping of our attitude towards these patients and through a liberal, but logical, use of supplementary essential food factors can we hope to have a wider success in the treatment of this group. The lack of exercise, the established pattern of food habits, the physical and physiological infirmities, must all be considered in dealing with these patients.

Third Circumstance: If a deficiency exists in an individual owing to faulty absorption of vitamins, concentrates will be of value.

Many examples of this variety could be cited. Of course, the classical example is the faulty absorption of Vitamin K in cases of biliary obstruction as the absorption of this vitamin, being fat soluble, depends upon the presence of bile in the intestine.

The absorption of Vitamin K may also be mechanically inhibited by the presence of non-absorbable mineral oils in the intestine. These oils presumably hold the vitamin in solution and prevent its absorption through the intestinal mucosa.

Other gastro-intestinal disturbances are prone to interfere with vitamin absorption. Patients, especially infants, suffering from acute dysenteries should have routine administration of the water-soluble vitamins and Vitamin K.

The preceding three circumstances have dealt with absolute deficiencies; in other words, they constitute deficiencies caused by subnormal quantities of vitamins reaching the functioning cells. The remaining two circumstances deal with relative deficiencies; that is, with deficiencies caused by an abnormal state of the functioning cells.

Fourth Circumstance: If a deficiency exists in an individual owing to biochemical interference with the activity of a vitamin, although it is present in normal quantities, concentrates will be of value.

One has an example of this vitamin interference in sulfa-drug therapy. It is

generally conceded that the bactericidal activity of these drugs is owing to their interference with the life functions of bacteria: so, too, do they interfere with the life functions of certain animal cells. The sulfa-drugs can inhibit the cells responsible for the production of white blood cells; such a condition, superimposed on the infection for which the sulfa-drugs are being administered, can result in a serious and, often, fatal disorder, known as agranulocytosis. Evidence suggests that the mechanism of this interference is an inhibition of the activity of folic acid, the newest member of the Vitamin B family. Without folic acid, white blood cell production virtually ceases. The existing infection destroys many of the already-circulating white blood cells. The result is a breakdown of the defensive mechanisms of the patient. In animals, at least, this agranulocytosis can be prevented and, if present, cured by the administration of ample quantities of folic acid.

In the example just mentioned it is to be observed that the inhibition manifests itself in a localized group of cells, the bone-marrow cells. Under other conditions localized interferences may occur. For example, some members of the R.C.A.F. complained of eye fatigue after flights over water in bright weather. They were found to be immensely relieved by administration of daily supplements of riboflavin. The investigators reasoned that the intense light inactivates the riboflavin in the eye, causing a localized deficiency with its resulting corneal vascularization.

Another instance of localized vitamin inhibition may exist in cases of terminal heart failure. The overwork of an inefficient heart may produce substances which interfere with the activity of nicotinic acid in the heart cells. This possibility was suggested by the improvement of certain cases of heart disease when they received generous doses of nicotinic acid amide. It might also shed some light on the activity of coramine, which has won such a high place among heart stimulants. This substance has the chemical structure of nicotinic acid with the addition of diethylamine. It is suggested that the altered nicotinic acid molecule might be able to circumvent the inhibiting factor and thus the nicotinic acid is allowed to function in the starved heart cells.

Inhibition may also be operating in those cases of arthritis which are benefitted by administration of large doses of ergosterol, electrically activated in a vaporized state. Of the Vitamin D group, this member is apparently the only one that can be safely administered in the quantities necessary to influence arthritis.

An interesting example of localized interference with vitamin activity is suggested by the finding that thiamin administration in adequate dosages minimizes the formation of the papule at the site of a mosquito bite and lessens or eliminates the itching. There is, however, some difficulty in explaining the report that this treatment causes an individual to become less desirable as a source of nutriment for mosquitoes.

Fifth Circumstance: If a deficiency exists in an individual owing to a suddenly increased vitamin demand over that which normally suffices, concentrates will be of value.

A sudden demand for extra quantities of vitamins may be either pathological or physiological. An example of an increased demand due to disease is the markedly elevated requirement for water-soluble vitamins during febrile diseases. Here the increased rate of metabolism demands extra amounts of those vitamins associated with carbohydrate utilization. Furthermore, the production of antibodies and white blood cells requires additional amounts of ascorbic and folic acids.

Because of the elevated metabolic rate, a physiological demand may occur

when a healthy individual undergoes severe physical stress. It has been demonstrated that the administration of a large single dose of nicotinic acid amide an hour or two before strenuous physical effort will prevent early exhaustion and loss of co-ordination.

A wholly understandable, physiological demand for extra vitamins manifests itself during pregnancy. There is undeniable evidence that water- and fat-soluble vitamin-supplements during pregnancy result in decreased maternal and infant mortality and morbidity.

Another type of physiological demand may result from an excessive excretion of vitamins. Salicylate treatment of rheumatic fever and arthritis initiates abnormal excretion of thiamin and ascorbic acid. The resultant deficiency may be so intensive that a neuritis may appear, associated with the haemorrhagic manifestations of a scorbutic state. Furthermore, salicylate treatment causes inhibition of Vitamin K activity, producing a deficiency of the clotting factor, prothrombin; thus, the scorbutic predisposition to haemorrhage becomes aggravated by a reduction in the ability of the blood to coagulate. This would indicate that all salicylate treatment should be supported by administration of concentrates of thiamin, ascorbic acid and Vitamin K.

Conclusion:

In the light of our present knowledge, these five circumstances exhaust the logical and, hence, legitimate uses of vitamin concentrates. Until, and unless, further information is available, the illogical use of vitamin concentrates is a fad, lacking both scientific and economic support.

By way of summary, one might refer back to the dietetic axiom previously stated and expand it in such a way that the five circumstances for vitamin therapy will be included: Sensible marketing and preparation of varied foods should provide every normal individual with sufficient energy-producing materials, proteins, minerals and vitamins; but where, under abnormal circumstances, absolute or relative deficiencies exist, concentrated sources of the deficient essential food factor may be employed advantageously.

The Silent Invader

SISTER PAULETTE FORTIER

The morning will always be in my mind when, my thoughts stirred by emotion, I stared at that large mass of bowel, just excised from a young woman's abdomen, having all the appearance of complete invasion by deadly cancer cells. I recalled the look of misery in that patient's eyes when with a kindly word of reassurance I strapped her to the operating table. The anguish that looked out of those eyes and the apparent hopelessness of two previous cases sent a shock through me and kept me wondering how many more unfortunates would come to surgery in the same condition. How many more would be the fata prey to that mysterious killer? How many more would be wrapped in that mantle of malignancy and pain? These thoughts awakened in my heart the desire to plead the cause of many thousands who, having the disease in an early stage, live without the slightest fear of the fate that awaits them. Hence, this urge to instil in the nursing profession and the general public the necessity of

minimizing this tragic drama and thus preventing the "silent invader" from entering other happy homes.

But I am ahead of myself, let me tell you about the three operations that made that morning exceptional. The surgeons had worked carefully on two similar cases prior to the one mentioned above. A peculiar oppressiveness and a quietness filled the operating room and seemed even to subdue the usual brightness of the white and green tiled walls. We could read thoughts in the doctors' minds, yes, they were our own thoughts, we were all overwhelmed by a sadness that came upon us when we realized that the best that science and skill had to offer fell short of the need. The patient either had not consulted her doctor in time or she had not noticed an obvious symptom. The third case that morning vividly illustrated the futility of curative efforts when the patient does not report her illness at an early stage. Mrs. W was now 36 years of age and, since her twenty-ninth year, had suffered discomfort and malaise; it had taken her seven years to muster the courage necessary to visit her doctor. The pain was at its gnawing stage before she would admit to herself that an invader had entered her body.

The second case illustrates a perfect textbook picture of the patient coming to a doctor but not reporting back. Her history tells us that a year previous to her admission to hospital, she had noticed a slight streak of blood after long walks or other exertion and had consulted her physician. After a thorough examination, not the slightest induration was noticed and she was told to report back. Symptoms gradually disappeared and, pressing activities taking up most of her time, Mrs. X failed to report until alarming symptoms developed. By then the disease had penetrated deeply into the cervix and, at the age of 41, desperately availing herself of all the skilled help the medical profession could offer, she was given some degree of comfort and solace. But now Mrs. X can count even the comfortable days that are left to her. This is just the type of case which doctors meet with that very serious difficulty, which, probably more than any other, is responsible for the many deaths from this disease. It is the want of knowledge on the part of the public generally as to the serious import of even a slight leucorrheal discharge with an occasional spot of blood. It is in the early stage that the diagnosis is most difficult, and it is in this stage that the diagnosis is most important, for operation then will in a large proportion of the cases save the life of the patient.

There is a tendency to censure the patient when she consults a doctor about a cancer that is past cure. Some are negligent, as we all know, and our first case that unforgettable morning is an undeniable proof of this fact. Mrs. B noticed a small lump in her right breast and was advised to have surgical attention However she had no inclination to follow this advice and two years later married. Shortly after marriage she became pregnant, the right breast became enlarged with a hard mass in it. Then she presented herself for surgery. The effect of pregnancy is to hasten the provour rapid extension of the malignant gress of the cancer and it seems to fagrowth. It was found that Mrs. B had a rapidly growing andeno-carcinoma of the breast. Radical surgery was carried out and, when the wound is healed, the patient will receive small doses of radiotherapy daily. But she will never rid herself of the invader which has too firm a hold on her by now. Mrs. B is only twenty-six years of age.

But are all these people to blame? Can we expect a patient to dash to her physician's office just because she noticed a spot of blood after exertion? We cannot expect her to know the importance of these symptoms if she has never been warned against them and what is more

if she has always felt quite comfortable physically. It is up to the doctor and the nurse to guard her health in this respect. So let us consider the very definite duties of the nurse in this matter.

Nurses are in a position to know the facts regarding the early symptoms of malignancy. Cancer control campaigns, widely established cancer clinics, and numerous articles published on the subject have done a great deal to educate the members of the nursing profession in this regard. There is, therefore, very little excuse for nurses lacking this fundamental knowledge. We nurses are in a position to help in that women tell us of conditions which might spell trouble, and often ask our advice before they consult a doctor. Therefore, we should be the first to stress the value and the necessity of seeing a physician *at once* when symptoms appear. We should be able to advise them in such a way that they will not be apprehensive but may expect that their visit to the doctor is to give them the comforting re-assurance that they are in good physical health.

Research workers of all nations labour valiantly in a desperate effort to snatch from the "silent invader" his deadly hold on the people of the world. But the fact remains that there is as yet, no serum, no vaccine, no specific prescription definitely to control cancer. The disease still baffles the ingenuity of modern science. But we have weapons, one is early diagnosis, another is competent treatment. This is our preventive programme, and its successful execution rests to a great extent with us, the nurses of the world.

We have hope in our hearts when we witness the wonders achieved by our skilled surgeons and physicians, when we see the marvellous results obtained with the miracle drugs which science is contributing to our age. Perhaps in a few years we shall have the "bayonet" drug which will reach down in the tissues where cancer plays havoc, and deal a death blow to this relentless killer. However, our greatest need today is to have the full co-operation of *nurses* in helping to prevent cancer. With great confidence then, I appeal to their love for suffering humanity, their desire to help others, their eagerness to make their lives useful to society and above all to each nurse's charity. Nurses can raise high the bright star of hope. Nurses can contribute immensely towards overcoming the blight that attacks so many of their sisters.

On the Home Front in Alberta

S. Elizabeth Heldal

I answered a knock at my door on a recent Sunday morning. A big half-breed Indian was there with a pair of steaming horses and a sleigh at the gate. "My wife is sick. She is alone. Can you come?" At the same moment a family from twenty-five miles away arrived with three small boys who needed their second dose of toxoid. I gave the inoculations and then started off to the maternity case. I knew this to be the third labour of a very pretty, young Swedish mother, and also the third breech presentation. I had written to hospital authorities, eighty miles away, asking for an address where she might wait pending the onset of labour so that she might be delivered in hospital. However, "there was no room for them in the inn". The case was mine.

It was a lovely sunny morning and the sleigh ride was enjoyable. The

horses trotted at a good pace with trace chains and bells jingling musically. Their hind feet were unshod and they slipped on the icy hills but did not fall. We met a neighbour and asked her to let the grandmother know of the expected event so that she would come and lend a hand.

The husband had recently bought land and had built a log house. It was unfinished and had no partitions or ceiling. Brown building paper was tacked to the walls to keep out draughts and some was left over and was very useful to me. A cord, stretched tightly across the centre of the house, held curtains of pink cretonne with big bunches of blue roses on it, so that the bedroom was screened from the kitchen. The mother had tried to do her washing before labour began but the clothes were still in the wash tub. Only the clothes for the wee baby were clean and dry.

The bed had an extremely ragged mattress, one dirty sheet, a pillow and patchwork quilts. I arranged the bed by folding some table oilcloth across the centre of the bed, and then covered it with lengths of the heavy building paper. Papricloth from my kit completed the arrangements. A long-furred grey cat was sleeping on the bed when I arrived and I rudely disturbed his slumbers! An eighteen-months-old baby presented more difficulty than the cat for whenever my back was turned, she crept under the curtain, through the rails at the foot of the bed and up to the head in less time than I write about it. Blocks raised the bed and settled that problem. Length of rough board were cut and laid across the rails of a child's cot, and were then covered with building paper. This flat surface made a good table on which I arranged my equipment, and had the advantage of keeping it out of the children's reach.

The husband was anxious to help so I instructed him to scrub to the elbows and also how to drop the chloroform on to the mask. His clean red and black checked shirt, blue denim pants and elaborate brass-studded belt lent a novel note of colour to the proceedings. In the meantime, the grandmother had arrived and finished the washing and then said that she would go to her home three miles away, and take the children with her. There was only dirty snow water in the house but there was time for the husband to haul a barrel of good well water from a farm half a mile away. There was no kettle and a rusty tobacco tin was used as a dipper.

Labour progressed with normal pains and the patient preferred to walk around. The membranes fortunately were tough, and when the os was fully dilated I ruptured them. Both legs were extended and were born with the buttocks as far as the feet. The next pain delivered the feet and I brought down the extended right arm. The head gave some trouble but the husband pressed downwards, I used traction, the mother provided a pain and the head was born. I quickly swabbed eyes, nose and mouth. The baby was rather blue and limp, but quickly drew his first breath and cried lustily. I placed the husband's hand in control of the uterus while I separated the baby from his mother and placed him to one side warmly wrapped. Placenta and membranes were expelled intact, and the loss of blood was moderate. The infant weighed eight and one quarter pounds and there was no perineal laceration.

I arranged warm oil and the baby's bath on the oven door, with the baby clothes, scales, cord dressing, silver nitrate, etc. on one end of a long stool. I sat on the other end. A very sweet little girl of two and a half, with big black eyes stood by me, watching the baby's toilet with interest. Each time he exercised his lungs, she laughed delightedly and said, "He gets mad!" Of her own accord, she handed me safety pins when

I was ready for them. A healthy little girl and a credit to her mother is this little Indian-Swedish-Canadian, and the new little brother will get the same living care from his parents.

I registered the birth of the baby and collected from his father the necessary fifty cents for a copy of the birth certificate. I also completed an application form for a ration book for the baby for, although he will be breast-fed, his mother will be glad to have his sugar ration.

New Officers of the C.N.A.

Representative of all parts of Canada, the new officers of the Canadian Nurses Association bring to their positions a broad background of experience in both professional and association work. Several of them have served on the National Executive previously. That the nurses of Canada may become better acquainted with them, a brief sketch of what each is doing will be of interest and value. A short outline of the career of the president, *Fanny Munroe*, R.R.C., was presented in the August issue of the *Journal* so we shall begin with the first vice-president. *Rae Chittick*, B.Sc., M.A., is a graduate of Johns Hopkins Hospital School of Nursing and from Columbia and Stanford Universities. Since 1926, she has been instructor in health education in the Provincial Normal School in Calgary. During the preceding biennium, Miss Chittick served the association as honourary secretary. The second vice-president is *Ethel M. Cryderman*, a graduate of the Toronto General Hospital School of Nursing. Following her service overseas from 1917-19, Miss Cryderman took courses with the Central Midwives Board in England and in public health nursing at the University of Toronto. After several years with official agencies, she joined the Victorian Order of Nurses and has been director of the Toronto branch since 1934. Through her presidency of the Registered Nurses Association of Ontario, Miss Cryderman is familiar with the very broad activities of the Canadian Nurses Association. *H. Evelyn Mallory*, B.Sc., the new honourary secretary, is a graduate of the School of Nursing of the Winnipeg General Hospital and of Columbia University. After experience in schools of nursing as instructor, supervisor and superintendent, Miss Mallory served for two years as registrar in the Registered Nurses Association of British Columbia. Last year she became associate professor in the Department of Nursing and Health, University of British Columbia. This is the second term in office for the honourary treasurer, *Marjorie Jenkins*. She graduated from the School of Nursing of the Hospital for Sick Children, Toronto and the McGill University School for Graduate Nurses and has devoted her professional career to pediatrics. She has occupied her present position of superintendent of the Children's Hospital, Halifax, since 1938. Being a woman of boundless energy, she has served as president of the Registered Nurses Association of Nova Scotia, an active member of the Soroptimists, Women's Canadian Club and the Business and Professional Women's Club.

Each of the Sections has a new chairman this year. The chairman of the Public Health Section, *Helen McArthur* was introduced in the August issue of the *Journal*. *Martha Batson*, chairman of the Hospital and School of Nursing Section, is a graduate of The Montreal General Hospital School for Nurses. Following her course at the McGill School

for Graduate Nurses, Miss Batson joined the teaching department of her home school. She has been educational director in this department since 1928. She has had wide experience as chairman of this section in the Registered Nurses Association of the Province of Quebec. *Pearl Brownell* assumes the chairmanship of the General Nursing Section after considerable experience as vice-chairman in this section. Miss Brownell graduated from the School of Nursing of the Winnipeg General Hospital and for fifteen years did private duty nursing in Canada, the United States and Bermuda. In 1936, she became registrar of the Doctors' and Nurses' Directory in Winnipeg.

Continuing her work as chairman of the Committee on Nursing Education, *Kathleen Russell*, director of the School of Nursing of the University of Toronto, rounds out the list of eminently capable nurses in whose trust the Canadian Nurses Association will go forward in this new biennium.

Health Conditions in Occupied Holland

An alarming increase in deaths among Hollanders under forty years old was disclosed recently in a report by medical experts on health conditions in occupied Holland. The rise was largely attributed to the phenomenal increased in diphtheria, cases of which have rocketed to over thirty times the pre-invasion figure.

The report, which just arrived in London from Holland, said that the overall death rate had increased from 8.6 per thousand persons in 1939 to 9.7 in 1943, which, it was said, was not unsatisfactory considering wartime conditions.

But when the figures were broken down it was revealed that the deaths of young persons had increased drastically. In 1939, the rate for the under-forty age group was thirteen per cent of the total death rate while in 1943 it mounted to nineteen per cent. This means that the average age of Hollanders dying in 1943 was considerably lower than in previous years. The report ascribed this increase largely to juvenile mortality caused by tuberculosis and diphtheria.

Infant mortality in 1943 however showed a drop over the 1941 rate, but was higher than that of 1939. Last year 39.1 babies died per thousand births, while in 1941 the rate was 43 and in 1939 it was 34.

In the meantime, the birth rate has been increasing. In 1939 it was 20.6 while last year it rose to 22.9—a fact that was attributed to an increased number of marriages.

The infectious disease rate remained fairly static during the early months of 1944, maintaining the level of the last months of 1943. The virulence of diphtheria, however, has remained most serious, weekly cases averaging 1,800. Deaths due to diphtheria totalled 2,388 in 1943, as compared to 213 in 1941 and only 75 in 1939. Tuberculosis deaths have almost doubled since 1939, mounting to 6,382 in 1943, as compared to 3,595 in 1939. According to the experts' report, this increase began in 1942 and has been mounting since.

The report further mentioned the "enormous increase" in stomach disorders and duodenal ulcers. This was ascribed to (1) neurosis (2) crude foods (3) the absence of soft fats such as butter and oil and (4) the lack of proper albumen.

Although the insulin supply is insufficient and this condition has been aggravated by exorbitant German demands, deaths from diabetes have not increased recently. The report added, however, that this can probably be ascribed to the fact that complications resulting from diabetes are often given as the cause of death.

The report concluded with the warning that there is a dangerous shortage of opium in occupied Holland, which is likely to have catastrophic consequences if doctors do not practice drastic economy in its use.

The Netherlands Government Information Bureau.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

The Ward's Contribution to the Education of the Student Nurse

HELEN E. PENHALE

Good patient care in its broadest sense is the ultimate objective of the educational program of any School of Nursing. The importance of experience in the observation and care of patients has been reiterated so many times that I shall refrain from repeating it except to say that the more years one spends in teaching, the more firmly one believes in its truth. We must not lose sight of the fact that the service to the patient always suffers unless we prepare good nurses. It is the aim of each of us then to contribute to the limit of our capacity to the educational needs of each student nurse. It has been said that the first casualty of any war is education. How true it is when we see depleted staffs trying to run our busy hospital wards; young people assuming responsibilities for which their years and experience have not prepared them.

We might represent the three-year period that the student spends in the school of nursing as a large circle made up of many sectors. The circle represents the best nursing care for the patient with the greatest educational value for the student. Each sector in the circle represents a block of experience on medicine, surgery, etc. Most of the real instruction which the student nurse receives is given by the supervisor and head nurse under whom she works and by the staff nurses with whom she comes in contact. Upon their shoulders falls the main responsibility for the kind of nurse whom we graduate. Just what should the service contribute in the way of experience? I am using "experience" here as including different types of nursing procedures, nursing problems and diagnosis.

Pearl S. Buck had occasion in June of 1943 to address a group of nurses who were graduating from Lincoln Hospital, New York. The appeal she made to this group was for a steadfast respect for the human individual — reverence for the individual personality. We are so inclined to think in terms of the masses — numbers and amounts, in excess of anything we can visualize. With the pressure of work in hospitals it is easy for us to think of patients, treatments, work to be done and students in this same manner. Miss Buck's warning is one we should stop and heed — we must maintain a steadfast respect for each individual student and for each patient assigned to our care.

Each clinical service to which the student is assigned must be set up in such a way as to contribute to the educational needs of the individual student. "In good nursing schools, teaching goes

on continuously whether the student is in the classroom or engaged in ward practice." Regardless of the adequacy of the classroom instruction, that which really counts is the opportunity we give our students to learn as they care for patients. The ward teaching program can provide many of these opportunities.

We should begin with a common understanding of the term "ward teaching". It includes the individual and group instruction given to the ward personnel (student, graduates, etc.) in or adjacent to the hospital ward and around which the nursing needs of the patient is centered. Much of the teaching is of the informal type. To the student nurse, the graduate represents the goal toward which she herself is striving. It is this which adds weight to the influence the graduate exerts, and power to the example which she sets. We perhaps have not realized nor appreciated the significance of the ward environment as a source of interest, stimulation and motivation, and as a setting for the personal and professional development of the student. Nor have we appreciated that much of what the student learns on the ward is by imitation. The other type of ward teaching is the planned or formal type such as the morning circle or the ward walk — those ten to twenty minutes that should be planned for each day.

The first difficulty that arises in carrying on any ward teaching is finding the time. The head nurse and supervisor's day is already filled with administrative routines. A study, sponsored in the United States by the American Hospital Association and the National League of Nursing Education in co-operation with the American Nurses Association, published under the title "Administrative Cost Analysis for Nursing Service and Nursing Education" attempts to determine the cost to an individual hospital of operating a nursing service with a school as compared to the costs without a school. Job analyses were done by the head nurse and supervisor in nurs- to determine the amount of time spent ing service and nursing education. It was found that only a very small percentage of the head nurse's hours on duty were spent in teaching — the remainder in administration. For the supervisor the figure was only slightly higher. According to the findings in this study it would appear that of her eight or ten hours on duty, less than sixty minutes would be spent in teaching. Some of the reasons for this very low figure centre around the following:

1. The head nurse does not feel that she has a part to play in the educational program of the school.

2. She may feel that she has no preparation and is therefore not able to teach.

3. Much pressure is exerted on the head nurse, so that she feels that the administrative routines must be carried out.

We all desire social approval. If the time slips aren't down by the prescribed time what happens? Perhaps the drug requisitions are delayed. Somewhere along the line, failure to carry out the administrative routines on time is going to bring the head nurse in contact with an irate department head. Who is upset if the student — Miss X — is not taught how to fix Mrs. Smith's dressing correctly? No one. The student doesn't realize perhaps that the service she is on, offers so much in the way of learning — or that there is a better way to meet this particular nursing situation. She does not know what to ask for in the way of learning situations. To summarize — For the head nurse to win the approval of or perhaps get along well with the various departments within the organization she must see to it that the administrative routines of the hospital are carried out. No such scheme has been set up to ensure that the head nurse feels the same sense of responsibility for the teaching side of her position.

To go back to the first difficulty — that of the head nurse not feeling a part of the educational system of the school. We must help her to feel an identity with the educational director for the education of the student. From the time the probationer first enters, the head nurse should be helped to feel that she is contributing to the pattern set up by the school for the type of nurse we wish to graduate. Could the students not practice as well on the wards under supervision, as apart in the classroom practising on "Mrs. Chase" or on each other? Do the people teaching the nursing arts tell the head nurse when they are teaching or have taught various procedures? The student could take to her ward a sheet on which is listed the approximate time that each procedure is to be taught. The head nurse then knows the student has had the procedure in the classroom and can now assign it to her on the ward. A further incentive for the head nurse is to have the student record the number of times she performs each procedure. You may feel that the student is not ready for this type of responsibility. Part of being an adult is assuming responsibility for oneself. Should not the student be made to feel from the very beginning that the business of getting a well rounded education both in the classroom and on the wards is part of her responsibility? In addition to serving this function it helps the head nurse in making assignments and in seeing what her service is contributing this month as compared wtih last or as compared with some other service. Not only can the head nurse and supervisor evaluate it but the educational office can see how much experience the student is getting. It serves as a means of giving the head nurse some recognition for her efforts. Out of a more active participation in supervision on the part of the head nurse may come suggestions for very much needed revisions in procedures. Both student and head nurse can feel that a contribution has been made.

Now for the head nurse who feels that she is not prepared to teach — that she doesn't know what to teach or how to teach. Those of us with more experience should sit down and help her. Somebody will say "and where are you going to get the time to sit down?" Out of all our busy lives one fact still remains — "The amount of time expended in one concentrated effort is more than repaid by the amount of time saved in helping and guiding a learner through a new experience and in her improved efficiency as a result of that guidance". Each service contributes a type of experience that the student can get no place else in the hospital. Take the surgical service as an example. The student learns here, and only here, about the actual physical preparation of a patient for the operating room; the skin preparation — how it should be done for this particular patient; the essential mental and emotional preparation. If the head nurse knew what her service was to contribute she would see to it that the job was done well, just as she sees to it that the administrative routines are carried out. Unfortunately, we have not analyzed each service in terms of its contribution to the total eductional program of the student.

In evaluating nursing procedures, or in teaching a new procedure we could help the young head nurse. In any type of teaching the instructor must know what she wants to accomplish. There must be a plan for teaching which reduces the job to its simplest terms but which is precise and definite and which includes all the important factors. It is all too easy for us, as teachers, to be so well informed about the topic that we skip over some of the essential points because they seem so obvious. We must analyze the job step by step and present it carefully, so as to be sure that we have covered all the important facts and that the plan has been reduced to a skeleton,

one in which all of the bones are complete. The head nurse should be familiar with the procedures as they are taught in the classroom. When supervising a procedure that procedure should be broken down into its essential steps. Most of you are familiar with Miss Stewart's score card for evaluating nursing procedures. In evaluating a procedure there are certain important points that should be observed. For example, some of the points we would note while observing the subcutaneous administration of a medication would be the reading of the doctor's order, counting respirations, checking and boiling the needle, the preparation of the tablet, etc. This type of supervision is not just inspection but includes guidance, research and administration. Instead of simply looking on, the head nurse assists the student by evaluating the procedure step by step. There is a common basis for evaluation and the personal element becomes much less significant. There should be an evaluation sheet worked out for each procedure. It serves as a tool through which to improve supervision and as an anecdotal record of the student's performance.

An additional problem is that of giving the head nurse recognition for her work. Many suggestions could be offered. Mention has been made of the assistance given her in making out assignments through the use of a form giving the approximate dates on which procedures are to be taught. She should feel more competent while watching the administration of nursing care through having assisted the nursing arts instructor with evaluation sheets for each procedure. Some of the procedures as taught in the classroom may be unnecessarily difficult or time consuming. Some procedures taught during the preliminary period may not be used and could well be omitted until the senior year. It is to the head nurse that we look for this type of information.

Our greatest problem is finding the time for teaching. The head nurse's day already seems filled. A few changes in her routine might help. Perhaps she could visit the patients at 9.30 in the morning instead of at 11. When it is done at 11, the ward is in order and rounds become chiefly "housekeeping rounds". At 9.30, the students are still busy administering patient care. Perhaps the head nurse could spend a moment helping the student adjust Mrs. Smith's binder so that it better serves its purpose, or offer a suggestion to the student who appears slow because of her inability to plan her work. On the doctor's round instead of remaining constantly with the doctor, she might excuse herself for a moment to help a student or even simply observe and evaluate the type of work that is being done so that she has concrete suggestions to offer later in guiding the student. A time budget for the head nurse seems in order. To-day she should plan to spend a minimum of so many minutes with each student. To-morrow this amount might have to be decreased, or increased, depending upon the ward activities.

Some of our ward activities have not been set up from an educational point of view. Could some of the non-essentials be eliminated and the time thus saved be used to better advantage? The work done by the head nurse should be critically evaluated; much of it could be assigned to less competent personnel leaving the head nurse more time free for teaching.

In addition to these problems, certain others come to mind. For example, how can we make the teaching that we do most useful to the student? The answer lies in statements from A Supplement to a Proposed Curriculum for Schools of Nursing in Canada: "Wants and needs are the primary sources of motivation in learning. The fundamental basis of all learning is self activity. We learn by doing. In order that there be

learning there must be a felt need for the material presented. The student should take an active part in the teaching and the material presented should centre around a ward problem". To introduce variety in our teaching we might teach from the point of view of symptoms rather than beginning with the diagnosis. For example, here is a patient suffering from symptoms such as dyspnea and edema. The question arises as to why she has edema. It may be for several reasons. Her treament is quite different if it is on a cardiac basis or on a kidney basis. If there are two such cases on the ward they might be compared from the point of view of treatment and nursing problems. We have an opportunity to review anatomy, physiology, chemistry, bacteriology — material that the student has had in other courses — and apply it in the care of the patient. This method lends variety and is not the same material that the student has had in the classroom.

Variety in the teaching program must be considered when planning for the senior student. The senior nurse on the floor is often one of the most disgruntled persons during her last few months in training. Why is she? Her experience may not have been graded so that she might assume responsibility for the relatively simple nursing problems during her first year and the more difficult nursing problems during the latter part of her training. Where we can not or for some reason have not had graded responsibility, we must plan something additional for the senior student. The third year student can often do much of the teaching for the younger group. She is going to be a head nurse, soon, if she remains in hospital work at all. There is little time to prepare her for the responsibility she has to assume. In fact, as a senior student she may be taking charge of a ward. It would seem advisable to teach her some ward management and supervision in her ward teaching program. Her senior year would be more interesting and she would be a better student head nurse as well as graduate head nurse.

Put your Books and Magazines to work for the Boys Overseas

Next to letters from home, reading matter is appreciated by members of the forces above everything else, judging by reports which come from heads of the services.

Here is a sample of the appreciation felt by men overseas. It comes from a letter from a district supervisor of the Canadian Legion War Services to the Central Book and Magazine Depot in Montreal:

"Your shipment of magazines arrived last week. Please accept my sincere thanks for your kindness. If you were here and could see the looks of pleasure on the boys' faces, especially the French boys when they found the French magazines, you would have felt, as I did, that anything we can do to entertain them is well worth the effort."

An urgent appeal is sent out to Canadians everywhere to gather up every available book and magazine and drop them in the book barrels to be found in all post offices and at many banks and stores.

Roll out the barrels.

Ethyl Chloride Treatment of Sprains

Interest in this procedure developed from investigation of effects of cold on tissues, the ice amputation, ice coagulation in wounds, etc. It was first done at Camp Borden where some thirty cases were treated. The cases chosen were those of sprain only, with no bony abnormalities and were mostly ankles, with some shoulders, wrists and backs.

Ordinary ethyl chloride spray was used and the most painful area as indicated by the patient was sprayed until a uniform whiteness is obtained, indicating that the superficial layers are frozen. The patient then walks or uses the part and, usually much to his surprise, all the acute pain is gone. He will usually indicate a further painful area, but this is always away from that part already sprayed. Several such areas may need to be sprayed. A little vaseline is applied over the frozen areas. The patient is then instructed to use the injured part thoroughly for the next two or three hours. (This must be emphasized, as if this is not done the method will fail). They are to return if there is pain the next day when the area may again be sprayed.

The success of this method lies in the period of active muscular activity which speeds the absorption and removal of the post-traumatic oedema in the injured area. The persistence of pain is due apparently to the pressure on the pain appreciation endings and most of it is referred to the cutaneous and subcutaneous skin areas involved. The ethyl chloride anaesthesia is transient, but since this works so well the effect on the pain appreciation endings lasts for much longer than previously realized. Similarly, much more of our pain appreciation must be superficial or referred superficially than was before realized. Only a few of the cases treated have had to return for further spraying. About one hundred and fifty cases in all have been treated at St. Michael's Hospital.

J. BATEMAN, M.D., R.C.A.M.C.
The News, St. Michael's Hospital

Specially Trained Psychiatrists

The importance of specially trained psychiatrists has been emphasized by the recent graduation of 140 medical officers from three schools of military neuropsychiatry in the New York area. Classes were conducted at the Mason General Hospital on Long Island, the Columbia University College of Physicians and Surgeons, and Bellevue Hospital Medical College under the direction of leading civil and military psychiatrists and neurologists.

Officers graduating from these schools have been ordered to duty in Army general hospitals to aid in the care and treatment of psychiatric cases. Most of the officers recently completed nine-month internships followed by special courses at the Army Medical Field Service School, Carlisle Barracks, Pennsylvania, and in general hospitals throughout the country. They then entered the schools of military neuropsychiatry for three months' intensive study in basic psychiatry and neurology. Their training will continue under the Chief of Neuropsychiatry at the hospital to which the students are assigned.

Office of the Surgeon General
Technical Information Division
Washington, D. C.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Occupational Therapy among Tuberculous Out-patients

ELEANOR C. WEIR, O.T. Reg.

Although occupational therapy is a comparatively new branch of the medical services, it is rapidly gaining recognition as a valuable aid in the treatment of a wide variety of human ailments. It had its real beginning as a profession during the last war, as an attempt to maintain and improve the morale of convalescing soldiers. For the next few years its greatest development occurred in connection with the treatment of the mentally ill, but within recent years its scope has broadened considerably until now it is regarded as an important aid to recovery in many orthopedic and medical conditions.

In dealing with tuberculosis, occupational therapy has a particularly important part to play, and the vast majority of sanatoria to-day are making use of its services. But what of the patient after he has left the hospital? The crowded conditions of our sanatoria make it imperative to discharge patients before their recovery is complete, and the sudden transition from sheltered institutional life, with its strict routine and discipline, to normal everyday living is often a very difficult one. Frequently the patient looks and feels well and there is a strong tendency to over-activity which eventually leads to physical relapse and rehospitalization. On the other hand, there is the patient who, through fear of another breakdown, becomes over-dependent and refuses to make any effort to resume normal activity.

The problem of dealing with such cases led the Metropolitan Health Committee of Vancouver, in May 1943, to employ through the assistance of the Municipal Chapter of the I.O.D.E. the services of a visiting occupational therapist to go into the homes of these patients and, through the medium of occupational therapy, help them adjust themselves. Patients are referred for occupational therapy by the Public Health Nurses and Tuberculosis Social Workers at regular monthly meetings. Each case is discussed in detail and the medical, social and occupational services are co-ordinated into one total plan to avoid duplication of effort and prevent confusion on the part of the patient and workers alike. Occupations are chosen according to the needs and interests of the individual patient, and carefully graded to provide progressive exercise as the patient's condition improves. Progress reports are presented every two or three months (oftener if necessary), and any new developments noted and incorporated into the total plan.

From the economic standpoint, occupational therapy has a definite part to

play. The majority of tuberculous patients are in the younger age groups when normally they would be at the peak of their earning capacity. The long period of hospitalization and subsequent protracted convalescence are a heavy drain on financial resources and normal resentment of total dependency frequently results in a premature return to employment. Occupational therapy can help relieve this economic pressure by giving the patient an opportunity to produce saleable goods, and his earnings, while not usually large, give him a sense of independence and security that is invaluable.

The psychological effects of occupational therapy can best be illustrated by quoting a few examples from actual case histories:

Case I concerns a girl of 19, referred for occupational therapy because she lacked outside interests, showed marked feelings of inferiority and tended to worry excessively over her condition. This girl, as it happened, displayed unusual craft ability and won so much admiring comment from friends and relatives over a pair of felt nursery pictures, which she made with painstaking care, that her own opinion of herself rose considerably. Gradually, as she progressed from success to success, she required less frequent encouragement and her confidence in herself and her ability to make decisions showed a definite improvement. Thus occupational therapy helped prevent this talented girl from becoming a self-absorbed neurotic by giving her a healthy means of winning confidence and social approval.

Case II is the story of ten men in a boarding home, all of them penniless and on relief with very few friends or outside contacts. Occupational therapy was prescribed with a view to giving these men an opportunity to earn a little pocket money and counteract the demoralizing influence of long dependency. The response was enthusiastic, and the improvement in their attitude towards each other and life in general was remarkable. The petty quarrelling and bickering which had been their habit, diminished at once and their social relationships improved as they developed their skills and began to help each other with their projects. The small income they received from the sale of their products bolstered their self-respect and gave them a feeling of independence many had not experienced for years.

Although the effects of occupational therapy are not always as obvious as in the above-mentioned cases, the great majority of the patients respond well to the treatment. It is to be hoped that the success of this experiment with tuberculous out-patients introduced by the Metropolitan Health Committee of Vancouver may stimulate other communities to set up similar services to bridge the gap between hospital and normal activity for this long neglected period in the life of the tuberculosis patient.

Preview

Recently we carried an appeal for greater inclusion of psychiatric training in the general professional preparation of the student nurse. In "What about Psychiatric Nursing?", Dr. C. M. Crawford will show us why we as nurses not only need a broader knowledge of psychiatry to assist our patients but also to keep our own lives on an even keel.

Today, we think of typhus as a disease of distant foreign lands with which our armed forces are coming in contact, a sort of "it couldn't happen here" point of view. Yet, just one hundred years ago, typhus took a fearful toll of life in Canada. Sister Paul Emile tells us of the part the Grey Nuns of the Cross played in combatting the epidemic at that time.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

How the Hospital Serves the Family

WINNIFRED ASHPLANT

Someone has said that the heart of a community is best revealed in its ministrations to the sick and suffering and in the saving of human life. When one considers how close is the relationship which exists between each member of the family and the hospital it can be truly said that the hospital is the heart of the community.

In considering the services offered by the hospital to the family it is well to consider first the functions of the hospitals. These functions have changed considerably throughout the years. In the early days, hospitals were looked upon merely as places where patients went to die. What a change has taken place since then! Who would have thought in those days that the time would come when there would be long lists of people waiting to enter hospital because they know that therein lies their best chance of making a quick and satisfactory recovery? To what may we attribute this change in attitude? Florence Nightingale said that nursing is an art which concerns every family in the world. Is it not good nursing and the facilities of the up-to-date hospital which attract families there to-day? Good nursing is one of the things which the hospital has to sell.

Almost equally important is its role in education. As the young daughter enters her training school to commence her training or the dietitian or occupational therapist enter to gain experience in home economics or occupational therapy, the hospital immediately becomes a center of interest to their families for it is here that these young students will receive the education which will prepare them for their future work. This interest of the family is further increased when a son enters the hospital to begin his term of internship. Here the young interne receives valuable experience which will enable him to make an important contribution to the community in which he lives.

The hospital has an important part to play in the promotion of health which should include close co-operation with all the health promoting agencies of the community. Through its diabetic, prenatal, mental and many other out-door clinics various members of the family are instructed in matters of health. On the hospital wards all patients and particularly the children are taught the value of cleanliness, proper food habits and the part occupational therapy plays in any health program. Nurses are alert to the possibilities of health teaching, and mothers are educated and guided in the proper care of their

children. Gladys Sellew, in her book, "Ward Administration", states that the orderlies, attendants, scrub-women, in fact, everyone who works in the hospital should be educated to see the relation of his work to the health of the community.

Mothers working through their Junior Leagues or on hospital auxiliaries and fathers acting on Boards of Governors or special committees make an important contribution to other families in the community. They interpret the facilities, advantages and problems of the hospital to those with whom they came in contact. This public relationship is extremely important, for these members with their insight and knowledge of the inside workings of the hospital are able to stimulate interest and to correct many false rumours.

Did you ever stop to think what it means to have a hospital in your community? If you have done so, you will realize that there is a great sense of security in having a place to which one may go in times of illness. This sense of well-being is even more evident in those communities with "Hospital Plans" which do away with the worry of hospital bills. We would not forget the important part which the social service department of the hospital plays in easing the burden of members of those families who have not suitable home conditions to which to return or suitable work to do when they are able.

Probably one of the most important functions of the hospital is the research work which is carried on there. Through the close study of all cases, recording of findings, research in nursing problems and matters pertaining to the care of the sick, progress is continually being made in the nursing services which are offered to the family.

In summing up, we might say (1) that the hospital stands ever ready to heal the sick; (2) that it carries on an educational program which is of benefit to all members of the family; (3) in promoting good health it makes the community a safe place to live in, and (4) it carries on a research programme which will eventually benefit every member of the family who may be ill.

Have You Heard?

Public School 116 in New York City was cited recently for "signal achievement in public health" and awarded a plaque. Not a single child among the 783 pupils had a cavity or dental flaw. Officials of the Board of Education and Metropolitan health and welfare agencies paid tribute to the accomplishment of the school.

— *Trained Nurse and Hospital Review*

Is there any public school in Canada that can boast of anything like as good a record? We would like to hear about it.

According to one authority, the decrease in food requirement follows a reduction of 10 per cent between 60 and 70, 20 per cent between 70 and 80 and after that 30 per cent less than calories required for the younger adult years.

—*Trained Nurse and Hospital Review.*

We can help elderly people to continue to be healthy and vigorous by paying some attention to their food habits. Well-balanced diets with a smaller total caloric intake can be obtained by reducing the amounts of carbohydrates consumed.

Dr. Pett, director, Nutrition Division, Department of Pensions and National Health, Ottawa, believes that the greatest single contribution to the future health of the nation is the establishment of a hot school lunch program in every community in Canada.

—*Canadian Home Economics Newsletter*

Notes from the National Office

Contributed by FLORENCE H. WALKER

Assistant Secretary, The Canadian Nurses Association

A Tribute

During the past year the Canadian Nurses Association has been fortunate indeed to have had Miss K. W. Ellis at the helm in National Office. Her close association with National Office activities from January 1942, when she became Emergency Nursing Adviser of the Association, enabled her to assume her new duties as General Secretary and National Adviser with a working knowledge of their nature and their scope. She was able to crowd into one short year an amazing record of accomplishment, a fact which will not be surprising to her many friends who know her ability, her industry and her splendid grasp of nursing affairs throughout the Dominion. Canadian nurses will heartily endorse the resolution of appreciation adopted at the General Meeting in Winnipeg, June 1944, when her untiring efforts in helping the Canadian Nurses Association to meet wartime problems was recognized and the lasting value of her contribution to nursing in Canada recorded. We have no doubt that nurses in Saskatchewan fully realize their good fortune in the return of Miss Ellis to the Registered Nurses Association of that province.

Bursaries (1944-45)

The national Bursary Award Committee met on July 19 to consider applications for bursaries which had been forwarded, with recommendations, from the provincial Bursary Award Committees. 129 final awards were made as follows: 115 for long-term bursaries; 14 for short-term bursaries. Long-term bursaries were awarded for university courses covering the academic year. Short-term bursaries were awarded for short courses in universities or hospitals. In a few cases where long-term bursary recipients were known to have received other awards, in the form of scholarships, etc., the full bursary of $500 was not granted. The list of bursary award winners will appear in the November issue of the *Journal*.

Seven provinces recommended long-term awards covering their long-term bursary allocations. The remaining two provinces have a balance which may be added to their short-term bursary allocation. It is expected that applications for short-term bursaries will continue to come in during the year. Provincial associations are reminded that the final date for the receipt of these at National Office is March 10, 1945, and that short-term courses being taken on 1944-45 bursaries must begin not later than June 1, 1945.

British Nurses Relief Fund

Even in the death throes of their last struggle for world power, the Nazi war-mongers have taken a heavy toll in Britain with their destructive robot

bombs. Members of the Canadian Nurses Association have been greatly distressed by the news that so many hospitals have been struck, resulting not only in serious casualties among the nurses and the destruction of all of their personal possessions, but also in grave loss of life both among the personnel while on duty in these hospitals and among their civilian patients — numbers which show a shocking increase. The nurses of Canada will be glad to know that in August a further donation of $5,000 was sent from the British Nurses Relief Fund for the relief of civilian nurses in Britain. Although a statement received earlier in the year from Miss Frances Goodall, secretary, the Royal College of Nursing, London, showed a substantial balance in the Canadian fund there, it was felt that the increased demands upon it indicated a replenishment.

Miss Grace M. Fairley, convener, Committee on Administration, British Nurses Relief Fund, has authorized the publication of the following extract from a letter sent to her by Miss Goodall:

> Now that there has been a renewal of enemy air activity and southern England has received visits from the pests sometimse called "doodle-bugs", we have been more than ever grateful for the generous gifts to the Civilian Nurse Air Raid Victims Fund. I hope you will be kind enough to tell the Canadian nurses, who helped so generously what it has meant to us all here to place a substantial sum at the disposal of Matrons of bombed hospitals, in order to cover the cost of immediate necessities for nurses who have lost all their possessions. The injured nurses, of course, receive continuous help through illness, recovery and rehabilitation. I think that immediate help is one of the things for which nurses are most grateful. When one is suddenly left without even a tooth brush or a spare hair pin, the feeling that someone has thought of you and provided you with shopping money is of as great moral value as it is of practical help.

We applaud the courage of our British sisters who have endured so much during the five years of war. They know that they can rely upon Canadian nurses for continued assistance in their hour of trial. There is still a considerable balance in the British Nurses Relief Fund, but should more be required, we know that the provinces will be ready to contribute further support.

Placement Service

A provincial Placement Service has been established in Winnipeg under the auspices of the Manitoba Association of Registered Nurses. It is one of the special projects made possible by the government grant for 1944-45. Miss Olive Thomas, R.N., has been appointed as director and the office is located at 212 Balmoral Street, Winnipeg.

It is expected that the new Placement Service will render valuable assistance to Manitoba hospitals and health agencies by ensuring the best possible distribution of available nursing service and so helping to supply their needs for nursing personnel. For individual nurses the new Placement Service has a program of counselling and guidance which it is hoped will help them to get located in positions suited to their interests and qualifications.

The Nurses' Directory is continuing, as in the past, to fill private duty calls. All requests by institutions or agencies for staff nurses should now be addressed to the Placement Director.

Syllabus — Assistant Nurse in Britain

Council members of the Royal College of Nursing met late in July to consider the draft syllabus of training for the assistant nurse, drawn up by the

General Nursing Council for England and Wales. This had already been sent to the House of Commons. A copy is to be found in the *Nursing Times* for July 8, 1944.

Members were of two opinions. Those who favoured the proposed syllabus argued the importance of adequate preparation and correct teaching from the outset for the duties that assistant nurses were already being called upon to do in the present emergency. The strongest opposition to it in its present form came from the Sister Tutor Section of the Royal College. The Section contended that it was too comprehensive; that it included procedures such as the giving of hypodermics which should not properly be regarded as the work of the assistant nurse; that the proposed examinations should be replaced by simple practical tests.

Other Council members felt that, if some uncertainty existed, it was better to include too little in the syllabus rather than too much, and to give extra instruction to those assistant nurses who showed themselves capable of profiting by it.

After prolonged discussion the Council agreed to ask the Minister of Health to receive a deputation to press for simplification of the syllabus, at least until after the experimental stage of its use.

In view of discussions as to the pros and cons of training subsidiary workers in Canada, and the shades of opinion as to the type of preparation which they should receive, this expression of British nursing opinion regarding a comparable group is interesting. Since in the Nurses' Bill of 1943 provision was made for the enrolment, regulation and control of assistant nurses by the General Nursing Council for England and Wales, British nurses at least have not the Canadian problem of obtaining protective legislation in nine separate provinces covering licensing and control of this group.

UNRRA — In the Wake of the Victorious Allied Army

In the February issue of the *Journal* Miss Johns stated concisely and clearly the functions of the United Nations Relief and Rehabilitation Administration. Events have moved with great swiftness in the arenas of battle and UNRRA has kept pace with the moving armies.

UNRRA is not an international charity organization, nor an employment agency for providing congenial jobs on the continent after the battles are over. It is limited in time, scope and constitution. It is concerned with helping nations to help themselves to the point where they are adequately self-sufficient to direct their own affairs. The expectation is that UNRRA will cease to function at the end of two years. However, during this period it is expected not only to supply food, clothing, medicine and necessities, but is responsible for the equal distribution of available stocks among the needy nations.

Valuable advice is contained in the reports of those who are already in action in the North African UNRRA camps. To quote one director:

> 1. The staff of any relief mission to an occupied country should be small and consist only of technicians and people who know the business of administration.
>
> 2. Relief missions will find in every country people who are willing to co-operate unselfishly and without political relationship. Local governmental and private agencies should be used to administer relief under Allied direction so that the work will develop through the people assisted.

In keeping with this advice, UNRRA anticipates employing a relatively small staff. In most cases it is likely to provide only a nucleus staff and will rely on local talent to carry on the work under its supervision. We have been warned that the Europeans will not be waiting for us with wide-open arms, however

benevolent our motives may be. These people want nothing so much as to re-assert themselves as independent, free people, once more masters of their Fate. We have food, they are starving; we have medicine, they are ill; we have clothing, they are destitute. All these things they must obtain from us, hence they will tolerate our presence during their trying rehabilitation days. But we must not overstay our time! More important, we must remember that there are competent men and women among the nationals who can do the jobs that need doing as they wish them done. The constitution of UNRRA protects the rights of each nation no matter how small, to direct its own development and control its own resources.

Those who are appointed to the staff of UNRRA are given a short course in the geography, history, social and political conditions, languages and customs of the countries to which they are to be assigned. This course is given at the University of Maryland. Lectures in tropical diseases are given at the Walter Reed Hospital, Washington. These studies and many more are continued at the training centre in Cairo.

Canada is contributing to the total effort of UNRRA all along the line. Our financial aid, amounting to $77,000,000 (1% of the national income) has been passed by Parliament. Several major positions have been filled by Canadians, namely: Miss Mary Craig McGeachy, Director, Welfare Division; George S. Mooney, Executive Secretary of the Administrative Council. In the medical and nursing field the following appointments have been made: Dr. Frank Pedley; Dr. R. R. Struthers; Miss Lyle Creelman, Chief Nurse, Eastern European Mission; Miss H. Kilpatrick, Miss Mary Henderson, Public Health Nursing Supervisors; Miss Frances McQuarrie, Hospital Supervisor; Miss Lazecho, Operating Room Supervisor.

Application forms may be obtained from the offices of Provincial Registered Nurses Associations and are to be forwarded by the applicant to Miss Lillian J. Johnston, Acting Chief Nurse, UNRRA, 1344 Connecticut Avenue, Washington, 25, D.C.

Letters to the Editor

Editor's Note: Two Canadian nurses who have recently been appointed to the staff of the Health Division, UNRRA, write of their initiation into this service in this informative letter:

We arrived safely in Washington with *all* our luggage. Our first impression was that it was a madhouse — such a commotion getting a taxi. There are so many taxis skipping around that one takes one's life in one's hand in crossing the street. The traffic lights are so complicated that we wait on the curb until some one else moves and then we follow.

After being mis-directed and walking the odd mile (it is actually about six blocks to the office from where we live) we reached the Health Division of UNRRA. We find however that very little detail seems to be available. Everyone is so good to us and seems to understand our utter confusion about sime things. Procedures are numerous but not in any way difficult. First we were sworn in, then went elsewhere to obtain a "travel authorization". This serves a dual purpose. It tells us where and to whom we are to report; it serves also as a requisition form for our issue of equipment and for our purchases at the quartermaster's stores.

There need be no worry about languages. Courses are provided here and continued overseas. The method of teaching is apparently phonetic; no grammar or written lan-

guage is given. We here now have the choice of talking either Serbsky or Greek, the choice being left to us.

A great effort is being made to recruit staff nurses. Qualifications have been lowered so that supervisory experience is not required for staff positions. Incidentally, for other nurses planning to come here, they should be advised to avoid postponing shopping until arrival in Washington. In our rush, we had to leave the odd things and depended on being able to obtain such items as over-the-shoulder purses and galoshes at the quartermaster's here. To our sorrow, neither of these articles is available. With the exception of those very few articles which can be purchased through the quartermaster, things are expensive here. With only the $150 we are allowed to bring, there will not be a great deal of money for shopping, particularly when it is suggested that traveller's cheques to the amount of about one hundred dollars should be taken overseas with us.

We get our cholera, plague, and yellow fever inoculations immediately, so we are getting our letters off beforehand. It is hard to say whether it will be possible to write again before we go. We will hope for definite information in the near future and will try to keep you posted on developments.

—Frances McQuarrie
—Heather Kilpatrick

Canadian Nurses for UNRRA

The Committee on Postwar Planning for Assistance Abroad announces with pride and pleasure the appointment of Miss Lyle Creelman, formerly Director of Nursing Service, Metropolitan Health Committee, Vancouver, as Chief Nurse, Eastern European Mission with UNRRA.

Other appointments from Canada include: Heather Kilpatrick, formerly Director of Public Health Nursing, Provincial Board of Health, British Columbia, and Mary Henderson, formerly field work supervisor in the Department of Nursing and Health, University of British Columbia, who have been selected for public health nursing supervisory positions with the Balkans mission; D. Lazecho, formerly on the operating-room staff of the Montreal Neurological Institute, and Frances McQuarrie, formerly travelling instructor with the Registered Nurses Association of British Columbia, who have been selected for positions in hospitals.

We extend to all these nurses our warmest congratulations and best wishes.

Left to right: L. CREELMAN, H. KILPATRICK, F. MCQUARRIE, M. HENDERSON.

A DIGEST OF BOARD RULES AND

Province and Citation	*Council* 1. How appointed 2. Personnel 3. To whom responsible 4. Term of office	*Board of Examiners* 1. How appointed 2. Personnel 3. Term of office 4. Powers 5. Remuneration	*School of Nursing* 1. Hospital bed capacity 2. Faculty 3. Curriculum 4. Inspection 5. Affiliations for schools in mental hospitals 6. Are regulations for conduct of nursing schools issued?
British Columbia "An Act respecting the Practice of Nursing" April 23, 1918. Amended: 1924–1935–1944.	1. Officers elected by popular vote, in accordance with constitution and by-laws. Chairmen by respective sections; councillors by district associations 2. 5 officers — chairmen of sections; district representatives as councillors 3. To the Association 4. Officers and chairmen, two years, elected in alternate years. Councillors elected annually	1. Council, subject to approval of Lieut.-Gov.-in-Council. 2. Five Registered Nurses; one member of College of Physicians and Surgeons, one member of Faculty of U.B.C. 3. One year. 4. All duties connected with examination papers, subject to approval of Council. 5. Not stated.	1. (a) General hospital, daily average of 50 patients; (b) general or special hospital, daily average of 50 patients with affiliation 2. Principal, night supt., at least one full-time instructor qualified to teach nursing; all members of the nursing staff Registered Nurses 3. Not stated 4. Provided for in constitution. 5. Not included 6. Yes
Alberta "The Registered Nurses Act." Incorporated 1916. Amended: April 1917 " 1919 " 1921 March 1922 " 1934 April 1941	1. Elected by Association 2. Elected officers plus chairmen of the 3 sections 3. University of Alberta 4. 2 years and no more than 2 consecutive terms	1. By the Senate of University of Alberta from names nominated thereto by the Council 2. Not stated 3. Not stated 4. Not stated 5. Not stated	1. (a) General hospital or hospitals with capacity of 100 beds. Daily average of 60 patients (b) Smaller hospitals — affiliation approved by University of Alberta 2. All to be registered in Alberta. Four doctors for teaching. Qualified dietitian 3. Curriculum — outlined in regulations issued by University of Alberta. Arranged by University of Alberta 5. Not stated 6. Yes

NURSE REGISTRATION ACTS

Candidate	*Examination*	*Registration without Examination*	*Other Data*
1. Age 2. Preliminary education 3. Professional education	1. Subjects fixed by whom. 2. Oral or practical. 3. Pass-mark 4. Number supplementary papers permitted.	1. To graduates within province 2. To graduates from other provinces, etc.	1. Registration fee 2. Renewal fee (annual) 3. Fee for supplementary examination 4. Penalty for delay in applying or arrears 5. Provision for reinstatement 6. Non-practising and absent members
1. 19 years for admission to school of nursing 2. High school graduation with University entrance 3. Pre-clinical affiliation with University permissible	1. Council regulations 2. None 3. Not stated 4. Not stated	1. Graduated before April 22, 1921. This waiver privilege to be withdrawn in 1948 2. Reciprocal registration with other provinces or countries having substantially the same requirements for registration	1. $10.00 (in constitution) 2. $5.00 (in by-laws) 3. Not stated (by Council regulation, $2.00) 4. In arrears automatically suspends from rights of registration 5. In constitution — fee for current year, plus arrears to a maximum of $10.00 6. Members not in receipt of remuneration or absent members pay annual fee of $3.00
1. Not stated 2. High school graduation Diploma — granted by Dept. of Education — Chemistry 2 and either Physics 2 or Biology included 3. 3 years in approved school or Bachelor of Science in Nursing from a recognized University	1. Senate of University 2. Not stated 3. Not stated 4. Not stated	1. None 2. Reciprocal registration for those registered under similar standards	1. $5.00 (fee for examination paid to University) 2. $3.00 3. Not stated 4. After the 15 days allowed, suspended as a member. Re-instated by payment of a fee of $3.50 for each year but not exceeding the sum of $15.00 5. May notify registrar — will be considered in good standing and be replaced on payment of fee for current year

A DIGEST OF BOARD RULES AND

Province and Citation	*Council*	*Board of Examiners*	*School of Nursing*
Saskatchewan An Act respecting the Saskatchewan Registered Nurses Association "The Registered Nurses Act." Assented to March 10, 1917 Amended: 1930	1. By Association and College of Physicians and Surgeons 2. 2 appt. by College of Physicians and Surgeons; 5 appt. by Association 3. Co-operation with University of Saskatchewan 4. One year	"All examinations and matters pertaining thereto under this Act shall be determined by and conducted by a board of examiners appointed by the University of Saskatchewan after consultation with the Council of the Association. R.S.S. 1920, 0.142, S. 10".	1. Outlined in regulations issued by University of Saskatchewan 2. Outlined in regulations issued by University of Saskatchewan. (Must be registered in Saskatchewan) 3. Minimum standard curriculum as approved by Senate of University 4. Inspection by school adviser — recommendations regarding approval sanctioned by Senate of University 5. Not stated 6. Issued by University — minute in detail
This Act provides		*for preparation and*	*registration of a "vi-*
Manitoba An Act respecting the Manitoba Association of Registered Nurses Assented to Feb. 15, 1913 Amended 1920, 1927, 1929	1. By Association annually 2. 15 members of Association in good standing 3. To Association called "Board of Managers" 4. Five elected annually to serve 2 years	"All examinations and matters pertaining thereto under this Act shall be determined and conducted by and under the direction of the Council of the University of Manitoba who shall appoint examiners thereof "	1. Daily average 20 patients 2. Must be Registered Nurses 3. Outlined in regulations governing conduct of training schools 4. By School Adviser and approved by Council of Association 5. At least 18 months —quality outlined 6. Yes, including curriculum
This Act provides		*for male and female*	*nurses and trained*
Ontario "Regulations pursuant to the registration of Nurses Act" Nov. 10, 1922 RSO 1927 C360 Amended: 1937-1938	1. Lieut - Gov. in Council 2. Not more than 8 & members 4. Deputy Minister Director (Ex-officio) plus 1 physician 1 yr 1 physician 1 yr 1 officer Dept. of Educ. 1 yr 1 Reg. Nurse 3 yrs 1 Reg. Nurse 2 yrs 1 Reg. Nurse 1 yr 3. To Department of Health	1. Minister of Health upon recommendation of Council 2. Not stated 3. Not stated 4. Director shall conduct or cause to be conducted examinations at least once a year 5. Not stated	1. A training school for nurses may be established, maintained and conducted in any hospital, sanitarium or university (1937) upon written consent of Minister of Health. (1938) 2. Supt. of nurses, asst. supt, night supt. and adequate number of nur-

(cont'd. on P. 790)

NURSE REGISTRATION ACTS

Candidate	*Examination*	*Registration without Examination*	*Other Data*
1. 22 years 2. Grade XI 3. As required and outlined by University of Saskatchewan	1. By University of Saskatchewan 2. Six written papers on fixed subjects 3. 50% individual subject; 60% over all 4. 2 subjects — re write for failure in more than 2	1. To graduates of Schools in Saskatchewan prior to March 10/17 or those who were students at that time and later graduated 2. Reciprocal registration provided for those whose credentials are satisfactory and who have been registered under standards equivalent to those in Saskatchewan	1. Exam. fee to University $ 8.00 Admission fee to Association $8.00 2. $3.00 3. $4.00 per subject 4. For delayed registration $8.00 plus annual fee for each year of delay "Arrears" 2 yrs. or less: Fee plus $1.00 "Arrears" – longer period — Arrears plus "Fine" as fixed 5. May resign
siting housekeeper"			
1. "Over 21 years" 2. Grade X (Certificate) Law Grade XI asked by all schools. Chemistry required prior to acceptance 3. At least 3 years courses for male and female students outlined	1. By Council, University of Manitoba 2. For preliminary session of exam. only — not in final 3. Not stated 4. Not stated N.B. British system of preliminary (Qualifying) Exam. at end of student's 1st year Final exam. after graduation	1. Special war-time provisions and temporary permits 2. Reciprocal registration provided	1. By examination $12.00 By reciprocity $10.00 2. $3.00 3. $6.00 for 1 subject $7.00 for 2 subjects 4. Renewal payable before April 1st. Fee plus $1.00 after that date. 5. May resign N.B. Assessment to meet emergency may be voted upon at general or special meeting
attendants course cov	*ering each, outlined in*	*Act.*	
1. At least 21 years 2. Junior matriculation, or equivalent approved by Board of Education 3. 3 years	1. By Minister of Health upon recommendation of the Council of Nurse Education 2. Not stated 3. Not stated 4. Not stated	1. Not mentioned 2. Reciprocal registration if registered under regulations satisfactory to Dept. of Health and where country or state where candidate registered extends similar privileges to Registered Nurses of Ontario	1. Not stated ($10 for graduate from outside Ontario) 2. $1.00 3. Not mentioned 4. Ceases to be Registered Nurse until payment of all arrears 5. None

A DIGEST OF BOARD RULES AND

Province and Citation	*Council*	*Board of Examiners*	*School of Nursing*
Quebec Association of Registered Nurses of the Province of Quebec Assented to Feb. 14, 1920 Amended: 1922-1925 and 1943 Name changed to Registered Nurses Association of the Province of Quebec	1. By Association 2. 14 members of Assn. in good standing 3. Association 4. Two years — may be re-elected, called "Committee of Management"	1. By Committee of Management 2. Two boards — Fr. and Eng., each 6 members of Assn. in good standing Assts. and experts on special subjects provided for in by-laws of Association 3. 3 years board — 1 yr. assistants 4. To prepare and conduct exam. for registration 5. Provided by Committee of Management. Equal representatives of Association board members on university board for French examinations N.B. British system including preliminary and final stages of exams in force — Spring 1945	1. Until Dec. 31.48, 50 beds 35 daily average patients After Dec. 31.48, 100 beds 60 daily average patients 2. Principal; night supt. and instructor qualified to teach nursing. All supervisors, etc. to be registered in Prov. of Quebec 3. English schools as proposed by C.N.A. French schools as required by University (14 schs.) others — C.N.A. used as guide 4. By school visitors 5. 12 months field outlined in Act 6. Not feasible up to present time — under consideration
New Brunswick "The Registered Nurses Act" Assented to 1916 Amended: May 1940	1. Elected by Association 2. Not more than 18 members including elected officers, conveners of standing committees and sections 3. To Association 4. Two years	1. and 2. Not more than 6 members (a) 4 members by Council, one of these being a dietitian and member of Canadian Dietetic Association (b) 2 members — medical practitioners appointed by Council of Physicians and Surgeons 3. (a) Members appointed by Council to serve 3 years (b) Members appointed by Physicians and Surgeons for such terms as may be provided by by-law 4. Power to prepare and conduct examinations 5. Not stated	1. General hospital with daily average of not less than 25 occupied beds (Quota of daily average may be met by affiliation for at least 6 mos. with one or more hospitals with daily average of not less than 50 occupied beds) 2. Minimum of 3 Registered Nurses, one of whom shall be a qualified instructor 3. Training in medical, surgical, obstetrical, pediatric nursing and dietetics 4. By registrar 5. Not stated 6. No

NURSE REGISTRATION ACTS

Candidate	*Examination*	*Registration without Examination*	*Other Data*
1. 21 years 2. High school leaving or matriculation certificate. "4 years of high school" 3. 3 years as described in Act	1. Board of Examiners 2. Written only until 1945 when used in preliminary session 3. 60% 4. May write supp. on 3 subjects, failure in more re-write Failure in supp. re-write all	1. None 2. Reciprocal registration for those registered under requirements not inferior to those in Quebec	1. $10.00 2. $2.50 (beginning 1945) 3. $1.00 per subject 4. No. Members in arrears shall pay annual fee for each year in arrears. Amount not to exceed $10.00 for duration of war Non - active fee $1.00. Those registered and practising elsewhere no renewal fee required
1. At least 21 yrs. 2. Junior matriculation or equivalent proved by Board of Education 3. 3 years	1. Board of Examiners with approval of Council 2. Not stated 3. Not stated 4. Not stated	1. Not mentioned 2. Nurses registered in any other province or country who are in good standing and whose qualifications are not below standard required by this Act	1. $10.00 2. Not stated 3. Not stated 4. Not stated 5. Not stated

A DIGEST OF BOARD RULES AND

Province and Citation	*Council*	*Board of Examiners*	*School of Nursing*
Nova Scotia "The Registered Nurses Association Act of Nova Scotia" April 1910 Amended: 1922 Name changed, 1931 1933, 1934	1. Elected by Association 2. President, and 3 vice-presidents; 2 secretaries; treasurer; 10 conveners of standing committees; 2 representatives of each "Local Branch" Total, 17 3. Independent 4. 3 years	1. By the Governor in Council Governed by rules and regulations of the executive committee 2. 4 members of Association and 2 members of Nova Scotia medical society 3. One year 4. Governed by rules and regulations of the executive committee 5. $5.00 per day and all expenses while actually travelling to and from the place of examination	1. Not less than 25 beds with 6 months affiliation with 50 bed hospital 2. The superintendent and night superintendent must be registered under this Act 3. Not stated 4. Not stated 5. 6. No
		This Act provides for	*the registration of male*
Prince Edward Island "The Registered Nurses Act" May 1922 Amended: 1933	1. By members at annual meeting 2. 7 in number: president; vice-president; secretary; treasurer and registrar, plus 3 members 3. Independent 4. Not stated	1. The board of directors of the three hospitals each appoint a member of their medical staff 2. The superintendent of training school of each of the 3 hospitals and 1 member of the medical staff of each of the 3 hospitals 3. Not stated 4. Not stated 5. Not stated	1. In hospitals having at least 50 beds, the 3 hospitals approved and mentioned in the Act. 2. Not stated 3. Not stated 4. Not stated 5. Not stated 6. No.
			Ontario *(cont'd. from P. 786)* se supervisors all of whom shall be Registered Nurses 3. Outlined in regulations 4. By inspector of training schools for nurses (a Registered Nurse appointed by Lieut.-Governor in Council) 5. Twelve months 6. Yes

NURSE REGISTRATION ACTS

Candidate	*Examination*	*Registration without Examination*	*Other Data*
1. At least 22 years of age 2. A grade XI certificate of education or equivalent approved by examination committee 3. At least 2½ years	1. Stated in the Act 2. Not stated 3. Not stated 4. Not stated	1. To the nurse who has graduated from an approved training school before April 29, 1925. 2. Reciprocal registration for nurses with substantially the same requirements	1. $10.00 2. $2.50 3. Not stated 4. Name removed from register after 2 years non-payment but replaced on payment of arrears 5. May resign in writing and on written request and payment of special fee of $5.00 be replaced without examination Assessments for special reasons provided for War-time temporary permits issued
and female nurses			
1. At least 21 years of age 2. Not stated 3. For at least 3 years	1. Not stated	1. To a graduate of an approved training school who graduated before the passing of the Act or within 3 years from the passing of the Act 2. (a) Reciprocal registration for nurses registered elsewhere where qualifications are approved (b) Interim certificate of registration for one year	1. $5.00 2. Annual fee $2.00 (active) 3. 4. (a) In arrears 2 years plus 3 months, forfeit membership (b) reinstated by vote of Council and payment of back dues 5. Inactive members $1.00 yearly

Interesting People

In August, **Alena Jean MacMaster** celebrated her silver anniversary as Superintendent of Nurses in her alma mater, the Moncton Hospital School of Nursing. After graduation, Miss MacMaster undertook post-graduate study for a year at the New York Polyclinic Medical School and Hospital. On completion of this course, she was appointed surgical supervisor of one of the operating rooms. Later she went to Tulsa, Okla. where for two years she was superintendent of the Physicians and Surgeons Hospital. From this post, she engaged in district and school nursing in Ossining, N.Y., returning to the Moncton Hospital in 1919. Under Miss MacMaster's superintendency the school has developed to its present status.

Both as a nurse and as a hospital superintendent she has long been at the head of her profession, being recognized as one of the outstanding Canadian nurses. She is a chartered fellow of the American College of Hospital Administrators, one of 14 women on the continent so honoured; a past president of the New Brunswick Association of Registered Nurses, and now president of the Moncton Chapter of the association; a past honourary treasurer of the Canadian Nurses Association.

ALENA MACMASTER

Mary Crossman (Saint John General Hospital, 1930; certificate from McGill School for Graduate Nurses in administration in hospitals and schools of nursing, 1939) formerly superintendent of nurses at the Aberdeen Hospital, New Glasgow, N.S. has accepted the appointment as superintendent of the Westminster Hospital, London, Ont.

Miss Crossman recently received her membership in the American College of Hospital Administrators, Chicago, being one of three Maritime nurses to hold this honour.

Mabel Faust (St. Boniface Hospital, 1931; McGill School for Graduate Nurses, 1934) has been appointed Nursing Consultant under the Pan-American Sanitary Bureau, with her headquarters in Rio de Janeiro, Brazil. For five years Miss Faust was superintendent of a hospital in Angola, West Africa, under the auspices of the United Church.

In 1941 Miss Faust went on a study tour of health education centres and hospitals in the eastern and southern states. The tour was sponsored by the Phelps Stokes Foundation of New York. On her return to Canada Miss Faust was appointed superintendent of the general hospital at Prince Rupert, B.C. She has been travelling instructor of the M.A. R.N. since January of this year.

Mildred Weir (Toronto Western Hospital and McGill School for Graduate Nurses) has resigned from the position of superintendent of the Hugh Waddell Hospital at Canora, Sask., to take over the duties of assistant superintendent of the Sarnia General Hospital. For two years Miss Weir served as a missionary in Formosa.

Bertha L. Pullen (University Hospital, Chicago; B.Sc., Columbia University) has been appointed director of the School of Nursing, Winnipeg General Hospital. Miss Pullen spent some nine years in Brazil with the Rockefeller Foundation as director of the Anna Nery School of Nursing, a Brazilian government institution. She has had travel experience in Europe under the Rockefeller travel scholarship plan. For the past five years she has been superintendent of nurses and director of the school of nursing at the Methodist hospital in Indianapolis.

Doris Shaw, formerly superintendent of nurses of the Sarnia General Hospital, has been appointed assistant director of nurses at McKellar Hospital at Fort William.

Isabel Stewart, formerly on the staff of Victoria Hospital, London, Ont., has been appointed superintendent of the St. Thomas Memorial Hospital, succeeding Miss **R. M. Beamish** who has accepted the position of general superintendent of the Sarnia General Hospital.

Mrs. Jane Clark (Children's Hospital, Winnipeg, 1921) has been engaged by the Peace River Municipal Hospital as matron. For a time Mrs. Clark served as night superintendent of Maternity at Winnipeg General Hospital. She did post-graduate work in obstetrics at Royal Victoria Montreal Maternity Hospital in 1940 and since then has been matron of the hospital at Nipawin, Sask.

Alice Girard (St. Vincent de Paul Hospital, Sherbrooke, P.Q., 1931; B.Sc., Catholic University of America, Washington) has returned to her work as director of the School for Public Health Nursing. University of Montreal, after an absence of a year during which she secured her Master's degree at Columbia University.

Pauline Marie Anne Capelle (Vancouver General Hospital, 1938; B.A., B.A.Sc., University of British Columbia) has been appointed as instructor and supervisor of public health nursing field work in

Garcia, Montreal

ALICE GIRARD

the Department of Nursing and Health, University of British Columbia. For several years she was nursing supervisor with the Division of Venereal Disease Control in B.C., responsible for the educational program for both under-graduate and post-graduate students. Miss Capelle has taken an active interest in nursing affairs and has served as secretary in the Registered Nurses Association of British Columbia.

PAULINE CAPELLE

MADELINE MCCULLA

Madeline L. McCulla returned to Edmonton this summer after a year in New York where she attended Teachers College, Columbia University, on a Rockefeller Foundation fellowship and took her Master's degree in nursing. Formerly senior nurse in the Lamont Health Unit, she graduated in 1938 from the University of Alberta with her B.Sc. degree in nursing. She was recently appointed to the position of acting director of the School of Nursing and instructor in public health at the University of Alberta.

Ann Isobel Black (University of Alberta Hospital, 1936; B.Sc., University of Alberta) has joined the staff of the School of Nursing, University of Manitoba, as instructor in public health nursing. Miss Black has been associated with branches of the Victorian Order of Nurses in British Columbia and in Ontario. For three years she was health teacher at the Winnipeg General Hospital.

Imperial Studio, Hamilton

ISOBEL BLACK

MAJOR B. G. HERMAN

At the request of the Lieut. (N/Sisters) of No. 3 Canadian General Hospital, Major (P/M) Riches forwarded a snapshot of their Captain (Matron) M. Roach which appeared in the June issue of the *Journal*. We were very pleased to receive the picture of another of our popular matrons, **Major (P/M) Blanche G. Herman**, in time for this issue.

Major Herman, a graduate of the Montreal General Hospital and for many years supervisor of nurses in the Western Division of that hospital, went overseas as Matron of No. 14 Canadian General Hospital in 1941. For these three years she has rendered excellent service, combining marked administrative ability with a very pleasant personality. Major (P/M) Herman has always been most willing to do everything possible for the Nursing Service. In 1943, Miss Herman was made a member of the Royal Red Cross, first class, an honour that was well deserved. Late in 1943 No. 14 Canadian General Hospital proceeded to Italy, and there again Major Herman's sterling qualities have had full scope. In May 1944, she was appointed to be Senior Principal Matron for the R.C. A.M.C. in Italy and at present is carry-

ing the dual responsibilities of that post and the duties of Matron of No. 14.

There is a lighter side to activities on our war fronts and our snap shows Major Herman in a very happy mood on a picnic in Italy.

R.N.A.N.S. Annual Meeting

The thirty-fifth annual meeting of the Registered Nurses Association of Nova Scotia was held at Kaulback Hall, Truro, N.S., May 4 and 5, with the president, Miss M. Jenkins in the chair. The meeting opened with a most inspiring invocation by the Rev. G. R. Thompson, of St. John's Anglican Church, Truro. Following this, His Worship, Mayor Kierstead of Truro, extended a cordial welcome to the Nurses Association, on behalf of the citizens of Truro. He spoke briefly on the great responsibilities placed on the nursing profession by the war. Miss Jenkins then welcomed the members, and Miss Norena Mackenzie as a special guest. She stressed the effect of the present social unrest of the world as a whole on the nursing profession, and the need of the united efforts to meet the problems of nursing service. She also pointed out the responsibility of each individual nurse in helping to meet the demands of the profession during this critical period.

The reports of the registrar-treasurer-corresponding secretary were presented. The number of active members shows a steady annual increase. Temporary reciprocal registration has been granted to twenty-four active members of other associations. Two special permits have been granted to graduate nurses who are not registered. It was noted that Nova Scotia has applied for reciprocal registration with England & Wales. It was decided that "as an emergency measure only, students who enter training school, during the war, be allowed to write their registration examination and become registered nurses upon successfully passing the examination, at the age of twenty-one years". The renting of larger office space at 301 Barrington St., on March 1, 1944 was announced.

The first report of the Nurses' Placement Bureau, which was opened March 1, 1944, in the same office as that of the R.N.A.N.S. and under the directorship of the present registrar, was given. Some publicity has been given the need for general duty nurses in smaller hospitals, sanatoria and mental hospitals. Questionnaires have been sent to all nurses who registered in this province at the national registration of nurses which was taken in 1943, in an effort to bring these lists up-to-date and place some nurses where the need is greatest. All branches reported small attendance at meetings due to the pressure of work, and, in some localities, transportation difficulties.

Through the recommendation of the Hospital and School of Nursing Section, a refresher course entitled "The Head Nurse" was given in five centres in Nova Scotia under the very able and interesting instructorship of Miss Norena Mackenzie, R.N. of the Province of Quebec. This course, which was financed by Government Grant Funds, proved most stimulating. The Public Health Section reported an expansion of services of all branches of public health nursing in the province, with special attention being given to the venereal disease program.

Miss Miriam Ripley, as a councillor to the C.N.A., gave an excellent report on the many and varied activities of our National Organization. Sister Catherine Gerard, convener of the Government Grant Committee, reported that bursaries had been awarded to twelve nurses for the full year course and five for short term courses. The tentative budget for 1944-45 was presented.

Miss Jenkins, convener of the Subsidiary Nurse Committee, gave a very comprehensive report on both the national and provincial study of this subject, and the progress made in this province up to the planning of an experimental course. She stated, however that due to information received that the Federal Government was considering such

a course, it was thought advisable to discontinue such plans until the details of the government plan were known.

The formation of a joint committee of representatives of the Registered Nurses' Associations of the Maritime Provinces with representatievs of the Maritime Hospital Association was reported by Miss Jenkins, who was appointed to form this committee at the January executive meeting. The purpose of this committee is primarily to discuss the ways and means of meeting the present shortage of nursing personnel in hospitals.

It was decided that the registrar, the incoming president, and Miss Catherine Graham, be sent as delegates to the biennial meeting in June. It was also decided to send the registrar to one general executive meeting of the C.N.A. during the next year, with expenses paid by the R.N.A.N.S. The invitation of the Pictou County branch to hold the annual meeting in 1945 at New Glasgow was accepted with pleasure.

The following officers and conveners were elected: president, Rhoda MacDonald; first vice-president, Mrs. D. J. Gillis; second vice-president, Sister Anna Seton; third vice-president, Gladys Strum; recording secretary, Lillian Grady; hospital and school of nursing section, Sister Catherine Gerard; public health section, Marion Shore; general nursing section, Miriam Ripley; programme and publication, Mrs. C. Bennett; legislative, Marion Haliburton; advisory to registrar, Sadie Archard; nominating, Jessie McCann; library, Frances MacDonald; past president, Marjorie Jenkins.

On May 5 the meeting adjourned and the members were taken to the Nova Scotia Training School, where Mr. H. R. Thompson gave a most instructive talk on the work of the school, followed by a tour of inspection. The work which this school is doing for those children who are intellectually retarded, by giving them appropriate training and vocational guidance, is remarkable.

The members then proceeded to the science building of the Agricultural College where they were the guests of the Truro Branch at an informal dinner, the catering being done by the Bible Hill Women's Institute. Mr. Eric Boulden, Superintendent of the Agricultural College, proposed a toast to the Services. Mr. F. H. Patterson, K.C., was the guest speaker and gave a most interesting talk on the history of Colchester County. As well as being most instructive as an historical subject, this talk was most refreshing to those members whose minds were overburdened with the problems of nursing, and it afforded much needed and pleasant relaxation in an otherwise extremely busy two days.

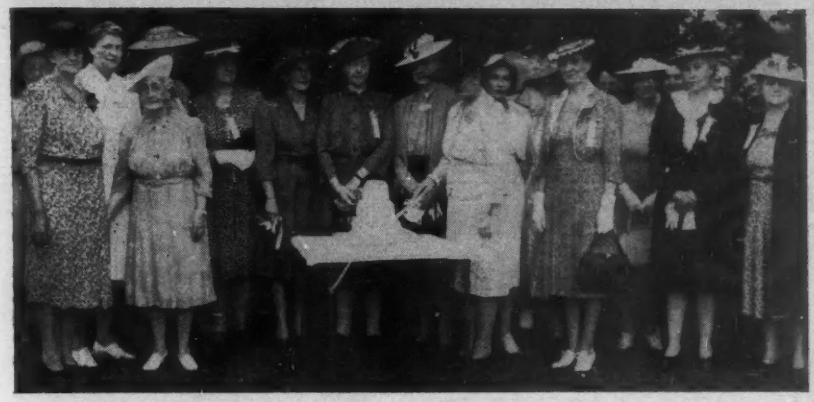
JEAN C. DUNNING
Registrar.

An Important Anniversary

June 1944 will long be remembered as a momentous date in world affairs. It was an important date also to the Alumnae of the McKellar Hospital Training School of Nursing, Fort William, Ontario, for it marked the fortieth anniversary of the founding of that school.

Away back at the turn of the century at a public meeting of citizens of Fort William, it was decided to provide for the nursing care of the young community by appointing a district nurse under the auspices of the Victorian Order of Nurses. Only two years later, the necessity of a hospital was clearly seen and Miss Christine Banks was appointed to organize the Victorian Order Cottage Hospital which was opened to admit eight patients. A citizen's committee was formed to solicit subscriptions and study possible sources of revenue. Many gifts were received the most notable being the block of land on which the present hospital stands. This was given by the McKellar brothers in memory of their brother John, who was Fort William's first and much loved mayor. In October 1902, Miss Mary McKellar laid the corner stone for the new building, and the following June, McKellar Hospital took over the functions of the Cottage Hospital, with Miss Banks as the first superintendent of nurses. One year later the training school was started, the first in the Thunder Bay

AN IMPORTANT ANNIVERSARY



Miss Olive Waterman cuts the birthday cake at the McKellar celebrations.

district. With a staff of three graduates and eleven pupil nurses, the first class completed its training in 1907.

Successive years brought increasing population to this Lakehead city and with various epidemics taxing capacity to the limit, new additions were built to the original hospital. The South wing, completed in 1909, increased the bed capacity from 30 to 120. Miss Elizabeth Davidson (Mrs. J. W. Cook), who was superintendent at this time, resigned in 1911 and was succeeded by Miss Ethel Johns. Two years later she was followed by Miss Isabel Johnstone, who after long and faithful service, died in 1923. Miss Pearl Morrison, the new superintendent, was a member of the first examining board for Ontario. Her successor in 1930 was Miss Barbara Bell, followed by Miss Myrtle MacMittan and Miss L. M. Horwood. Today, with Miss Olive Waterman as director of the school, McKellar has a bed capacity of 240. The hospital is unable to meet the needs of the community and plans are being made for a new 400-bed hospital. The nurses' home has been too small for many years. In 1942, Senator and Mrs. N. M. Paterson presented their home and property to the McKellar Hospital as living quarters for the nurses.

The Alumnae Association was organized in 1923. Its members are proud of the fourteen graduates who served overseas in the first world war and the seventeen who are at present on active service.

During the week of celebrations, sponsored by the Alumnae Association, graduates from all over Canada and the United States as well as several of the former superintendents gathered in Fort William. The program of entertainment began with a welcome tea on Tuesday, June 30, followed by the joint dinner with District 10. At the garden party on Wednesday afternoon, the three-tiered birthday cake was cut by Miss Waterman. Miss Elizabeth Smellie, a native of the Lakehead area and, at one time night superintendent, gave an inspiring address at the graduation exercises on Thursday evening. A dance on Friday night and motor drives on Saturday with a picnic supper at Chippewa Park concluded the festivities. A final function was the special church service held in St. Andrew's Presbyterian Church on Sunday morning.

The celebrations were rich with renewed acquaintance and pleasant memories. McKellar Hospital and its alumnae look forward to many happy years of service to the community.

Preview

Increasing interest and attention are being focussed on the war in the far east. We are privileged to bring our readers a letter from Matron Annie Edgar telling of her experiences among the wounded soldiers in India.

STUDENT NURSES PAGE

A Study of Tuberculous Meningitis

VIDA C. ABBOTT

Student Nurse

Brantford General Hospital School of Nursing

Babe Carol was born in hospital on September 27, 1942, of Canadian parents. Her father, who was a foundry worker, is on active service overseas, and is reported to have good health. Her mother, a slight, pretty young woman of twenty-seven, with perhaps less than average intelligence, is apparently well, and had a normal pregnancy and delivery.

On discharge from hospital the mother and babe went to live with the maternal grandparents and their family of six children in third-rate rooms above a small grocery store on the main street of D. The living conditions at this place were anything but healthful. The hallways and rooms were dilapidated, dirty, untidy and very poorly ventilated. The family was noisy, and usually had several callers who sat about smoking incessantly. Babe Carol lived at this home from birth until February, 1943, when her mother took her by train to visit the paternal grandparents at M. where they stayed until October of that year. When they returned to D, the mother became employed in a factory, and the babe was left in the grandmother's care during the day.

Babe Carol's mother did not take advantage of the helpful advice and information available at the well baby clinic, nor seek any help from a social service worker. The babe was breast fed until she was fourteen months old, the breast feeding being supplemented early with vegetables and other suitable foods, as well as pasteurized milk. Although her diet may not have been entirely adequate, she developed into a fairly well-nourished, happy, active child, with lovely fine fair hair, and large, bright, hazel-brown eyes. She teethed, walked, and talked at the normal time, and had no illnesses until January, 1944, when she began to develop the early symptoms of tuberculous meningitis.

Tuberculosis in the first two years of life is a very serious condition. At any time or age its onset is insidious, and is caused by the entrance of the tubercle bacilli into the body, the disease most commonly affecting the respiratory system. It is characterized by a destructive process and replacement of normal tissues with tubercles, which may produce both local and constitutional reactions.

The early symptomatology of tuberculosis; a tuberculous focus in the body; tuberculosis: loss of appetite, followed by loss of weight. In some cases it would seem to be acute miliary tuberculosis with localization of the infection in the meninges, and in others a local condition due to the spread of tubercle bacilli

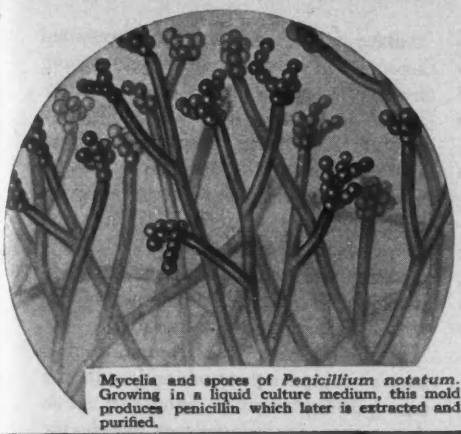
from a tuberculous focus in a cranial bone. The predisposing factors are: Contact with an open case of tuberculosis; a tuberculous focus in the body; pertussis or influenza. The child becomes irritable and wants to be held where previously it was content to play by itself, and the whole disposition appears to change. There are changes in circulation with flushing and paling, gastric upsets, constipation, repeated colds, and bronchitis with a cough.

The first signs of tuberculous meningitis often make their appearance simultaneously so as to give the general impression of a sudden onset. Usually, the history of the early symptoms is obtained after the history of symptoms which relate to the central nervous system have appeared. Later signs and symptoms are: headache; vomiting and convulsions; low grade fever with a high temperature later; rigidity of neck; positive Brudzinski, Kernig, and Babinski signs; eye changes, such as ptosis, strabismus and nystagmus; paralysis, and coma in the terminal stage. Laboratory findings are: positive tuberculin test; miliary tuberculosis usually shown by x-ray; white blood count 5000 to 15,000; spinal fluid clear with pressure increased, having spider web pellicle, and finding of organism in the fluid, with cell count increased, and sugar and chlorides decreased. The prognosis is grave.

In January, 1944, a change in Carol's disposition was noticed. She became irritable, had a cough, and continually followed her mother about asking to be taken up. She would often lay her head on the couch and put her hand up as if her ears ached. Her appetite continued fairly good, however, and she slept well. Early in February she had a cold and sore throat, developed a temperature, and after a convulsion, she was brought to hospital. Following a mustard bath, a colonic irrigation, and the administration of tartar emetic no. 2 her condition appeared to improve. After a few days the vomiting ceased, but she continued to cough, and was so fretful that she was discharged February 19 in the hope that she would convalesce better if she were more content. The diagnosis at this time was pharyngitis with convulsions because of temperature.

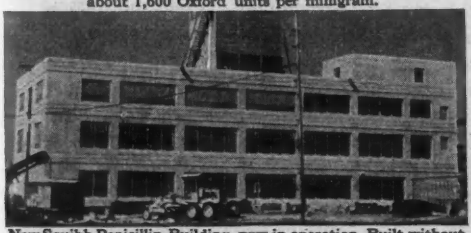
At home Carol remained irritable and continued to cough. Her throat seemed very sore and she developed an elevated temperature and an erythematous rash on her chest on March 4, when she began to twitch, became unconscious, and was re-admitted to hospital with a tentative diagnosis of a typical scarlet fever. The rash disappeared the next day, and she remained listless, tossing her head from side to side. Excepting for these symptoms, all physical findings were essentially negative, including an electro-cardiograph which was made to rule out the possibility of rheumatic fever, as well as repeated examination of her ears. The urine showed 2-plus albumin and in view of the fact that the white blood count reached 26,500, sulfathiazole grs. 7½ q. 4. h., and then sulfadiazine grs. 2½ q. 4. h. were given, with no change in condition or temperature except that the urine became clear. Babe Carol refused nourishment at first, but gradually took liquids in small amounts, and her elimination was good. "Homecebrin" dram 1 daily was given to insure vitamin requirements.

On March 17 a Vollmer Patch proved positive, and an x-ray was taken with the report that there were signs of broncho-pneumonia. The next day the babe's eyes were roving to and fro without focusing, there was some rigidity of the neck, and the first evidence of a high pitched cerebral cry. Lumbar punctures were made on three successive days, with clear fluid obtained under considerable pressure. With the report on these specimens it was possible to make a definite diagnosis, since there was a negative Wassermann. The cell



Mycelia and spores of *Penicillium notatum*. Growing in a liquid culture medium, this mold produces penicillin which later is extracted and purified.

Crystals Penicillin Sodium Squibb X100. In the course of studies concerned with the chemical structure of penicillin Dr. H. B. MacPhillamy and Dr. Oskar Wintersteiner were first, July 1943, to accomplish crystallization of penicillin sodium; activity about 1,600 Oxford units per milligram.



New Squibb Penicillin Building, now in operation. Built without government subsidy, it is designed and equipped for the most efficient production and control of penicillin. Instead of a few pounds, now over a ton of mold is grown each day. Its productive capacity is not exceeded by any other penicillin plant in the United States.

Unusual care maintains purity, activity and stability. Workers package Penicillin Squibb in air-conditioned rooms sterilized with ultra violet light. For over two years Squibb has produced penicillin for the National Research Council and the Armed Forces.

SQUIBB HAD *Penicillin* READY

WHEN the War Production Board's Office of Civilian Penicillin Distribution recently announced the limited allocation of penicillin for civilian use and the plan for its distribution, the Squibb Laboratories were ready with a substantial supply after having first met the requirements of the Armed Forces, Lend Lease and the Office of Scientific Research and Development.

The Squibb Laboratories have been actively engaged in the development and production of penicillin ever since the first culture was received from England in the autumn of 1940. Remarkable changes have occurred in the method of manufacture. Huge tanks have replaced bottles for growing the mold; production time is less than three days instead of two weeks.

It is hoped that the day is not too distant when penicillin production will be sufficient to eliminate the need for allocation. We want physicians to know that Squibb is doing everything possible to hasten the coming of that day.

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count was as high as 104, with a lymphocyte count of 93, the sugar and chlorides were decreased, and a spider web pellicle formed, in which acid-fast bacilli were seen.

From this time the babe's condition grew steadily worse, the neck rigidity increased, she whimpered when handled, she continued to hold the right side of her head, began to grind her teeth, became unable to swallow, and there was drooling. The eye changes were varied. Patchy inflammatory spots appeared on her abdomen and thighs, which were attributed to laking of blood vessels. The low grade fever persisted throughout, with final elevation of 103.6°. Her respirations became shallow and sighing, then laboured, and the pulse was weak and rapid. The restless movements of her hands and feet continued, and finally there were muscular twitchings of her hands. She was given aspirin gr. 1 q.3.h., which it was felt did help to control the restlessness, and phenobarbital gr. 1/8 to prevent the recurrence of a convulsion.

As a typical case of scarlet fever, Carol was placed in the isolation ward in a separate unit, and continued to be cared for in this way even though it early became evident that she did not have this disease. A gown and mask were worn in caring for her, all linen was disinfected with H. T. H. 15-1/5%, and dishes sterilized by boiling. As it was evident that either her head or her ears ached, her room was kept quiet and well ventilated, with a screen placed between her crib and the window to prevent any draught and to keep direct light from her eyes. In the daily bathing and general care an effort was made to handle her as little and as gently as possible to minimize the increased pain from the cerebral irritation. Glycerin suppositories were used occasionally, as well as milk of magnesia dram 2, to insure elimination. She was kept clean and dry at all times.

Babe Carol's nourishment presented a problem in that she refused anything from a spoon, or that was not liquid. It was found that by taking her gently in one's arms and supporting her head and back she could drink in small sips from a cup. In this way she was fed with milk and orange juice in small quantities at frequent intervals, and her medications given, as long as she could swallow. Because of the nature of the disease gavage was not indicated.

A mouth gag made from a wooden tongue depressor wound with adhesive tape was kept near at hand for use in the event of a convulsion. With the constant restless movements, her heels became slightly red, and woollen stockings were used, which also served for extra warmth. As she began to drool a small gauze dressing was placed against her cheek to prevent it from becoming irritated, and her lips were moistened with liquid paraffin, with the result that they did not evidence the degree of dehydration which she must have reached finally. While the nursing care could be directed only to the alleviation of symptoms and the comfort of the babe, it was felt that something had been accomplished. The disease terminated fatally on March 26.

Although it was not considered that this form of tuberculosis was infectious, terminal disinfection was carried out as a precautionary measure. The bed and mattress were aired in direct sunlight for six hours, the washable part of the unit scrubbed with soap and water, and the linen disinfected. The thermometer was soaked in Sterilol 5% for half an hour, and the utensils used in the care of the babe boiled for five minutes.

Every doctor and nurse in charge of a little child suffering from any form of tuberculosis must make every effort to discover the *source* of the infection. The disease and fatality were reported to the Board of Health of the City of D., and the Medical Officer of Health

required all the members of the household to have chest x-rays. Babe Carol's mother was x-rayed in connection with her factory employment and the result was negative, and her father had not been at home since her birth. It was found that another child, a boy of six, was suffering from primary tuberculosis.

Generally it is easier to limit infection during the first two years than later, and because contact with tuberculous individuals can be definitely regulated, and pasteurized milk can be used. Babe Carol, because of the living conditions of the family, was exposed to contact with innumerable people, both at home and through travelling as an infant. Both she and the boy of six may easily have contracted the infection from the same outside source.

The opportunity for the observation and care of this patient and the study of the literature in regard to tuberculous meningitis was of great value. In her future work the writer feels that this nursing care and study should make her more alert for the signs and symptoms of this disease. It has also served to more keenly impress on her mind the need for the support and continued effort of everyone concerned with health work in the program of prevention and early discovery of tuberculosis.

Personnel

The distribution of interns is not as widespread as formerly. There is a tendency for the interns to stay in the hospitals in the larger centres. In some instances the larger hospitals are accepting more junior interns than hitherto, presumably to compensate for the shortage of seniors and residents. There is a strong demand on the part of non-teaching hospitals, particularly those at a distance from medical schools, that interns be rationed. In view of the basis upon which internships are now taken, however, this would not seem to be a likely development.

—*Hospital Personnel and Facilities*

Hospital personnel has been very seriously affected by the war. There has been a tremendous turnover of staff among both skilled and semi-skilled workers, one large hospital reporting a personnel turnover of 186 in one month. This, of course, has meant not only considerable disorganization but an actual loss in efficiency of operations because of the lowered average degree of qualification among the replacements.

—*Hospital Personnel and Facilities*

Book Reviewing

Over a period of time, a very considerable number of books come to the *Journal* office for review purposes. In order that everyone may keep abreast of the large field of literature which is available, it is important that each book be reviewed while it is still new. In reviewing any informational or scientific text, it is reasonable to expect that the person selected to write the review should have fairly detailed knowledge of the field which the book covers, in order that its worth may be judiciously appraised. Since there are so many specialized branches of nursing, no one person or even a select few are qualified to adequately report on the broad range of books which are received. It is planned therefore to invite various persons with authoritative knowledge to prepare reviews for publication in the *Journal*. In order that there may be a degree of uniformity in these reviews, then, this outline may serve as a guide.

J. Donald Adams, editor of the Weekly Book Supplement of the New York Times, stated: "A satisfactory book review should do three things. It should, as far as possible, make clear to the reader what the author of the book undertook to do; it should give him also, a skeleton knowledge of the book's contents; and finally, it should leave in his mind a definite impression of the book's quality."

The reviewer must decide in the beginning what was the exact purpose or intention of the author in preparing the book. Differences which distinguish it from others of its class should be noted. Is it convincing in its treatment of the subject? Is it stimulating? Indicate clearly and concisely the general nature of the work. Show by illustrations how the writer deals with some of the more important topics. Quote, in moderation, to illustrate the points being discussed. It is quite in order to devote more space to reporting on the content than to make a critical appraisal. The reviewer has an obligation, however, to point out "facts" which are inaccurate and inferences which are unsound.

In making a judgment of the book, the reviewer should develop a truly critical approach. Does the writer really reach his objective? Does he seem to be biased in his point of view? If so why? Does he neglect any important phases of the topic? Does his writing possess style, good diction, clear and forceful presentation? Is the book a real contribution to the subject with which it deals? Has the writer gone to the fundamental sources for his information? Criticism involves comparison and contrast if it is to interpret the book for the reader. The review should indicate what readers will find especially interesting or valuable. Is it for the elementary student or the advanced specialist?

The preparation of book reviews takes time and few nurses have much of that precious commodity to spare today. However, the editor will be grateful for any assistance which may be received in the preparation of sound book reviews.

—M. E. K.

Book Reviews

Massage and Remedial Exercises in Medical and Surgical Conditions, by Noel M. Tidy. 480 pages. Published by John Wright and Sons Ltd., Bristol, England. Canadian agents: The Macmillan Company of Canada Ltd., St. Martin's House, Toronto. Sixth edition, 1944. Price $7.50.

Though relatively few nurses include the skills of massage and medical gymnastics among their professional attainments, the information which Miss Tidy incorporates under causes and symptoms of the wide variety of medical and surgical conditions included in this text, will be of very real value to them. The details of treatment are beyond the nurse's scope in most instances, yet there are many exercises recorded which would be extremely useful additions to the nurse's knowledge.

After a thorough coverage of conditions which may affect bones and joints, such as fractures, dislocations, sprains and various disease conditions, including arthritis, the author describes in considerable detail the lesions which may occur in various parts of the nervous system with the resultant muscular deterioration. Valuable information on various types of deformities of the lower extremities and the spine, including some of the less well known and obscure conditions is included, as is also data regarding diseases of the heart, respiratory organs, and the abdominal and pelvic organs.

Because nurses are so continuously on their feet, they will be interested in Miss Tidy's listing of the causes and treatment of pes plano-valgus or ordinary flat feet. The actual causes are listed as: unsuitable footwear; habitual wrong posture, either in walking, or, worse still in standing, the foot being allowed to remain for long periods in an exaggerated "position of rest" — that is in extreme eversion. Since nurses do have to stand so much, they would profit from the suggested forms of treatment.

The book is well illustrated with photo-

graphs which were taken as motion pictures, and, after the whole film had been seen on the screen, the positions which gave the best idea of each exercise were chosen for reproduction.

A useful reference text for school of nursing libraries.

Gas and Air Analgesia, by R. J. Minnitt, M.D. 74 pages. Published by Baillière, Tindall and Cox, London, England. Canadian agents: The Macmillan Company of Canada Ltd., St. Martin's House, Toronto. Second edition, 1944. Price $1.50.

Planned primarily as a handbook for students qualifying under the Central Midwives Board in England, there is a careful description of the mechanism of the Minnitt apparatus and detailed instructions on its use by the midwife in home deliveries. "The important feature of this machine lies in the provision of a special device which draws in atmospheric air along with the nitrous oxide, ensuring a uniform mixture of gas and air irrespective of the depth of inhalation".

The advantages of this means of reducing the pain associated with labor are apparent. Since the analgesic is self-administered, the patient can anticipate the approach of severe pains and by inhaling the gas twenty seconds before the pain's onset, can minimize its severity.

This handbook would be of interest to nurses in outpost hospitals if such apparatus were available to them. In Britain, however, the midwives are only permitted to use this mechanism with their patients under a physician's supervision.

An Experiment in Applied Nutrition for Canadian Communities, by Edna M. Guest, O.B.E., M.D. and Ethel Chapman. 192 pages. Published by West Toronto Printing House, Ltd., for the Swift Fellowship. 1943.

A compendious report of the survey of Canada's nutrition program made by Miss Frances I. McKay, the sixth of a series of university fellowships donated for this purpose. Details of the planning for education in nutrition as organized in the provinces, with specific reference to developments in certain areas of each are outlined. Much was accomplished in awakening a lively interest in this phase of Canada's health. There is still a very great deal of education necessary before the general public is fully aware of its nutritional needs and how they may be met.

Guiding the Normal Child, by Agatha H. Bowley, Ph.D. 174 pages. Published by Philosophical Library, New York, 1943. Price $3.00.

Though there are many books available today on the problems of childhood one that approaches the topic from the point of view of what may be expected at the various age groups, what constitutes normal development and how satisfactory adjustment can be made of difficulties which may arise, is a worthwhile addition to any school of nursing library. Because it is written primarily for student teachers there is an absence of scientific phraseology which might prove a stumbling-block to the young student nurse. Occasional illustrative case studies help to clarify the more abstruse points. Parents, too, will find lucid explanations of such things as feeding difficulties, destructive behaviour, and so forth.

The book is divided into sections dealing with infancy, the pre-school period, the middle years of childhood and adolescence. There is an especially interesting discussion on children and the war. We in Canada have not experienced so violent an impact with the war as have the families in Britain yet the principles of "Mental First Aid" which are outlined might very well be applied to all of us here.

In Dr. Bowley's opinion children's fears or anxieties of one kind or another reach their highest peak at three years of age. Contrasting with the theories which have been propounded previously, Dr. Bowley suggests that the most frequent causes

of fear among pre-school children are animals, mysterious events, and strange persons. Particularly, the child of this age fears loss of love and loss of security even in situations where he is surrounded by love and care. These irrational fears call for extremely careful handling because they are basic to other more evident fears the child may exhibit.

The brief section which discusses delinquency and anti-social behaviour has considerable significance today. Dr. Bowley concludes that delinquency is due primarily to some form of deprivation which may be of physical, social, intellectual or emotional origin. "Anti-social behaviour is characteristic of all stages, but it is most common from about 7 years onwards. In fact, young delinquents, as research studies and child guidance experience have shown, really start their delinquent careers at about 7 or 8 years. The peak of the delinquent period is usually said to coincide with the peak of the gang age, at 10 or 11 years. There is usually a further increase of delinquency at the mid-adolescent period, when inner stresses find an outlet in delinquent behaviour". Nurses should be familiar with the causes and assist as far as possible in reducing the incidence of delinquency.

M.L.I.C. NURSING SERVICE

Germaine Dupuis (Hotel Dieu of St. Joseph Hospital, Montreal, and University of Montreal public health nursing course) was recently transferred from the Quebec City nursing staff to Jonquière, P.Q.

Alice Bastien (Hotel Dieu Hospital, Montreal, and University of Montreal public health nursing course), formerly in Jonquière, was recently transferred to the Quebec City nursing staff.

Alice Gallant (St. Jean de Dieu Hospital, Gamelin, and University of Montreal public health nursing course) recently resigned from the company's service. Miss Gallant worked on the Montreal staff since May 1929.

Alberta Department of Public Health

The following are the staff appointments to, transfers, and resignations from the Provincial Public Health Nursing Service of Alberta, and the Health Units:

Gladys Anderson has been transferred from the Maloy district to the Youngstown district.

M. Kirstine Anderson, who has been relieving at Tulliby Lake while *Anne Nordtorp* attended Summer School, will be stationed permanently at Bonanza. Miss Nordtorp has returned to the Tulliby Lake district. *K. Herman, B.Sc.*, who has been stationed at Bonanza, is on leave of absence for one year to do organization work in the McLennan-Spirit River Health district in the Peace River country.

M. A. K. Davis, B.Sc., Craigmyle, and *Ethel Jones*, Foremost, have opened new districts at these points this year.

Hazel Dearing, Blueberry Mountain district, resigned to be married and will be living in her district.

F. M. Harrison of Hines Creek has been away on sick leave and will be returning to the Maloy district. *Beth Laycraft*, formerly of Whitemud Creek, has settled down at Hines Creek for the winter. *Mrs. S. E. Heldal* has been relieving at Whitemud Creek since Miss Laycraft came out to attend Summer School and is staying on for the present.

Margaret Hodgson, Dixonville (our most northern district) is on leave of absence to be married and will return to her district for the winter. A resident nurse is taking emergency cases in her absence.

Jean Kellner of Fort Assiniboine was married while on her holidays but returned to her district until *Isabel Cruickshank* took over this fall.

Isabel Miller, B.Sc., public health nurse in the Child Welfare Clinic, Edmonton, left the staff on the return of *Blanche Emerson* to take charge of the Clinic after service as superintendent of public health nurses for the past year.

Hazel Wilson, following completion of her public health course at McGill School for Graduate Nurses, has been stationed in the Lindale district.

Naomi Pow of the Lomond District has resigned to return to hospital service.

Dorothy Colgan has been relieving at Alder Flats while *Mrs. K. P. Cole* is on leave of absence and holidays but will be stationed at Lomond later in the fall.

Mary Willis has been transferred from Youngstown to Worsley to give her an opportunity to put into practice the knowledge she acquired from the advanced course in obstetrics she recently took.

Mildred E. Blake, after a year's leave of absence, has returned to the Newbrook district.

Seven new *Health Districts* have recently been opened with appointments as follows: *P. Routledge, B.Sc.*, Strathmore health district; *Thora McMullen*, Rocky Mountain House health district; *Dorothy Myers*, Pembina health district, Westlock; *Beatrice May*, Athabasca health district, Colintown; *Beryl Tiffin, B.Sc.*, Macleod health district, Granum; *Kathleen Herman, B.Sc.*, McLennan-Spirit River health district; *Nina Newton*, Brooks health district.

The following appointments have been made: *E. Orme, B.Sc.*, to the Red Deer health district; *Mrs. G. Davis*, to the Rosebud health district, Didsbury; *J. Cramer, B.Sc.* and *Verne Rowe*, to the Foothills health district, High River; *Jean Axeltine*, to the Stettler health district; *E. Sturgeon, B.Sc.* and *Mrs. Mary Zukiwisky*, to the Lamont health district.

Nance Cuyler, Legal health district, is leaving to join the V.O.N. in Toronto.

Mrs. P. V. Ross (Edna Cammaert) has resigned from the Lamont health district to join her husband in Halifax.

Psychiatric Nursing Course

A four-months post-graduate clinical course in psychiatric nursing is now offered at the Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal. The course will commence on January 1, 1945, and will include 120 hours of teaching in addition to clinical instruction. For further information write to the Supervisor of Nurses, Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal.

The short-term bursaries from the Government Grant have not yet all been awarded.

Inquire from your Provincial Registered Nurses Association if you apply for this course.

Fire Prevention Week

The week of October 8 to 14 will once again be observed nationally as Fire Prevention Week. Managements of occupancies housing large numbers of persons have been more alert to the danger of fire than many others in their communities. Everyone who serves the public directly is only too well aware of the loss of good will and confidence a serious fire will involve.

Yet even these buildings continue to have fires — about 10,000 of them a year, representing a financial loss of more than $5-000,000. That is merely *direct* loss. No one has yet found a way to evaluate lives lost, injuries sustained and all the other indirect losses experienced. Moreover no one knows today when a structure damaged or destroyed by fire can be repaired or reconstructed.

There is little that can be done for the duration to rectify hazardous construction. But a less expensive and perhaps even more effective, method of strengthening fire defense lies in the training of personnel. Training in the exercise of safe practices will prevent many fires from starting. Training in prompt fire control will minimize damage if fire does start. In most communities, the local fire department is glad to help train workers.

Canadian Fire Loss: The fire loss in Canada for 1943 was $31,464,710; it was $31,182,238 in 1942, and $28,042,907 in 1941. The ten fire causes heading Canadian property loss lists were:

1. Defective electrical wiring and appliances	$3,200,458
2. Stoves, furnaces, boilers, and smoke pipes	2,909,308
3. Miscellaneous known causes	2,580,088
4. Careless smoking	2,862,407
5. Defective and overheated chimneys and flues	1,772,491
6. Petroleum and its products	933,676
7. Exposure fires	855,782
8. Incendiarism	607,283
9. Lightning	540,031
10. Sparks on roofs	513,454

—*National Fire Protection Association.*

Facts About Dwelling Fires

It is estimated that more than half of all our fires occur in homes. About 7,000 people are killed, and about twice that number are injured every year; many of the victims are asphyxiated or trapped by smoke, fire gases and flames. While municipalities have adopted ordinances to assure safety in places of public assembly, conditions in residences are generally controlled by the people who build or live in them.

What Causes Dwelling Fires: Some 400,000 fires occurred in homes during the past year and the majority of them were attributed to one of the following causes: rubbish, defective chimneys, sparks on flammable roofs, defective heating equipment, careless smoking and use of matches, flammable liquids, electrical defects.

What to do to Prevent Dwelling Fires: Most dwelling fires are preventable. A room-by-room check should be featured during Fire Prevention Week, and householders should observe the following points:

1. Check from cellar to attic, inside and outside buildings, for rubbish and remove it promptly. Rubbish is a double fire hazard: it may ignite spontaneously, or it may serve as quick fuel for a stray spark. Send it to your salvage committee or, if entirely worthless, burn it in a covered wire incinerator as far from buildings as possible.

2. Oily rags, like rubbish, may ignite spontaneously. Burn them if practical; otherwise store them in closed metal containers. Paints, too, should be kept tightly covered.

3. Heating systems should be examined for cracks or other defects, soot, or clogging in chimneys and flues. Repairs should be made promptly. Make sure that no combustible material, including woodwork, is exposed to heat.

4. Keep ashes in covered metal containers; shield fireplaces with screens.

5. Replace weather-worn flammable wood shingle roofs with fire-resistant roofing.

6. See that ample ash trays are available wherever smoking is permitted, and that careful smoking habits are cultivated by all members of the family.

7. Put matches in metal containers out of the reach of small children. Use a flashlight for temporary illumination.

8. Use great care with any flammable liquid brought into the home for any purpose. Do not use flammable cleaning fluids. A correctly built fire needs no kerosene.

9. Replace frayed electric cords, have defective electrical equipment replaced or repaired by a competent electrician, check the fuse box to see that proper fuses are installed, and see that lamp shades are a safe distance from electric light bulbs.

10. Recharge fire extinguishers and put them where they will be readily accessible if a fire should break out.

—*National Fire Protection Association.*

Nurses in Britain will, in the near future, be able to marry in white—and coupon-free—thanks to the Royal College of Nursing which is now organizing a supply of lease-lend wedding dresses and head-gear from the United States.

—*Nursing Mirror*

Obituaries

Annie J. Hartley, R.R.C., veteran nursing sister of the first world war, died recently at her home in Brantford, Ontario. Graduated from the Toronto General Hospital, Miss Hartley served in England, France and aboard hospital ships at Malta and Gallipoli. In 1920 she became matron of Christie St. Hospital and later Matron-in-Chief of Hospitals, Department of Pensions and National Health. She retired from active work in 1936.

Mrs. Marion Tillinghast (Marion Wilson, Royal Victoria Hospital, 1934) wife of Dr. Arthur Tillinghast of New York, was drowned recently in Lake Temagami.

Charlotte McMahon (Royal Victoria Hospital, 1941) and Ida MacGregor (Royal Victoria Hospital, 1916) died recently after long illnesses.

Mrs. Alexander Forbes, a pioneer nurse, died recently in Toronto. After graduating from the Toronto General Hospital, she went to Canora, Sask. and organized the Hugh Waddell Hospital for the Presbyterian Church. When gold was discovered in the Yukon, she organized a band of nurses with whom she arrived in Dawson City in the dead of winter. After four years as matron of the Good Samaritan Hospital, she organized and took charge of the Alberta public health nursing department. She also spent a year as superintendent of nurses at the University of Alberta Hospital prior to her marriage to Dr. Forbes, Presbyterian minister and pioneer of the west.

NEWS NOTES

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

District 7

The quarterly meeting of District 7, R.N.A.O., was held recently at the Hotel Dieu Hospital, Kingston. Representatives from the Brockville and Perth Chapters were present. Miss L. D. Acton, convener, Hospital and School of Nursing Section, presented her report giving an excellent survey of wartime conditions as they exist in the hospitals of this district and telling of the parts that the married nurses, nurses' aides, and Red Cross auxiliary workers have played. Miss Acton gave a talk on the Government Bursary recently extended to nurses qualified to follow post-graduate courses.

Miss D. Morgan read a letter from Miss C. McCorquodale, convener of the Administrative Committee of the Permanent Education Fund, announcing the election of Miss Morgan to membership on the Permanent Education Fund Committee. An excellent report on membership was presented by Mrs. D. Ferguson who announced a substantial increase in membership. Miss G. Connely

was appointed convener of the Public Health Section.

A Committee on Epidemics was appointed after the chairman read correspondence from Miss Maude Hall. It was moved that Miss Connely, senior nurse, Public Health Department, Kingston, would act as chairman of this committee with Mrs. Lillian Gilpin and Kathleen Walsh, Brockville; Bertha Griffin, Perth; Amy Church, Smiths Falls; Mrs. C. W. Jackson and Florence Latimer Kingston, as her assistants. The above members will offer assistance if required in organizing the district in case of an epidemic occurring. An excellent report on the R.N.A.O. convention was presented by Mrs. E. Kipkie on behalf of the two delegates who attended.

The guest speaker was Dr. Edwin Robertson who took as his topic "The pre-operative and post-operative care of the gynecological patient". A delightful lunch was served by the Reverend Sisters and graduate nurses of the Hotel Dieu Hospital.

QUEBEC

Montreal General Hospital:

Major Kennedy-Reid has returned to England from the continent of Europe to take charge of a 1200-bed hospital and Miss Hewton has been promoted to Acting Major to replace Miss Kennedy-Reid as matron of No. 1 Canadian General Hospital. Louise Shepherd takes Miss Hewton's place as assistant to Major Herman, in Italy, with the rank of assistant matron. Helen Hewton, Cecil MacDonald and Joan Gray have recently been awarded the decoration of A.R.R.C.

Edith M. Simms, B.A. has resigned from the teaching staff and is now in charge of the teaching department at the Victoria General Hospital, Fredericton. Miss Simms's place is taken by Anna Christie who will be assisted by Mildred Brogan. Kathleen Clifford has returned to the nursing staff after a year's study at the McGill School for Graduate Nurses to fill the position of surgical supervisor. Those attending the School this coming term are: Mrs. MacDougall (Isabel Snider), Bernice Connor, taking the degree course; Mary I. Lane, B.A., Mrs. Hecht (Mary Kobayashi), and B. Hawley, courses in teaching and public health nursing; Elsie Schroeder in the science department for a special course relating to biochemistry; Eleanor Hood takes first year medicine. Margaret Denniston, who has been assisting in the Training School Office for the last eight months, after completing one year at the University of Minnesota where she obtained her B.Sc. in nursing, now leaves Montreal to attend Teachers College, Columbia University, in order to continue her studies.

Psychiatric Nursing

Stating that "the need for psychiatric nurses is so great that it cannot be overemphasized", Mrs. Laura Fitzsimmons, Nursing Consultant of the American Psychiatric Association, presents an earnest plea in the article, Facts and Trends in Psychiatric Nursing, in the August issue of the *American Journal of Nursing* for the "education of the public to the needs of mental patients, so that funds will be available to raise the care of all mental patients to an acceptable level" and for increasing affiliations in psychiatric nursing for student nurses.

A survey of the nursing care provided patients in 80 mental hospitals in 34 states and 4 provinces of the Dominion of Canada, undertaken by the Nursing Committee of the American Psychiatric Association in 1942, revealed that the ratio of registered nurses to patients ranged from 1 to 3, to 1 to 2,864. The ratio in state hospitals visited averaged 1 nurse to 400.48 patients; private hospitals averaged 1 nurse to 15.67 patients; psychopathic departments of general hospitals averaged 1 nurse to 7.07 patients.

Some of the other facts brought out by the article are:

1. Poor salaries paid in mental hospitals, long hours and poor living conditions have not been conducive to attracting personnel.
2. In thirteen states no course of any kind in psychiatric nursing is given, but in one state and the District of Columbia, every student has this experience.
3. The great handicap to the conduct of affiliate courses in psychiatric nursing is lack of persons prepared to conduct such programs.
4. Nurses prepared to work in the field of mental hygiene for the promotion of mental health are needed.

—The Nursing Information Bureau

WANTED

Applications are invited for the position of **Provincial District Nurse** in the **Province of Alberta.** Districts located in rural areas. Cottage, water and fuel supplied by community. **Salary:** Minimum of $1500 per annum, plus Cost of Living Bonus. Sick leave. Annual vacation provided after one year's service. Apply to:

Miss Helen G. McArthur, Superintendent of Public Health Nurses,
218 Administration Bldg., Edmonton, Alta.

WANTED

A Clinical Supervisor is required for the **St. Catharines General Hospital.** The salary is $95 per month, and full maintenance. Apply, stating qualifications and experience, to the:

Superintendent, St. Catharines General Hospital, St. Catharines, Ont.

WANTED

An **Assistant Night Supervisor** is required for the **Verdun Protestant Mental Hospital;** also nurses for **General Duty.** State in first letter experience, references, etc. and when services would be available. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.

WANTED

Four General Duty Nurses are required **immediately** for the **Tranquille Sanatorium.** The salary is $129.92 per month, including Cost of Living Bonus; $27.50 is deducted for maintenance. Half of single tourist fare refunded after 6 months service. Apply to:

Miss G. M. Currie, Superintendent of Nurses, Tranquille Sanatorium
Tranquille, B. C.

WANTED

Graduate Nurses are required for **General Duty** in a small, well-equipped hospital. Pleasant surroundings; good living conditions; eight-hour duty. Salary, $22 per week (less income tax) with full maintenance. Apply to:

Superintendent of Nurses, Anson General Hospital, Iroquois Falls, Ont.

WANTED

An experienced **Obstetrical Nurse** is required to act as **Assistant Superintendent** at the **Mount Hamilton Hospital, Hamilton, Ontario.** 131 Obstetrical beds and Medical Wing. Applicants must be qualified to assume teaching responsibilities. Apply in care of:

Box 30, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

WANTED

Two Registered Nurses are required for the **Barrie Memorial Hospital** in **Ormstown** for the positions of **Assistant Lady Superintendent** and **General Floor Duty.** Good salary. Address applications to:

Miss L. A. McKell, Superintendent, Barrie Memorial Hospital, Ormstown, P.Q.

Official Directory

International Council of Nurses

Executive Secretary, Miss Anna Schwarzenberg, 1819 Broadway, New York City 23 New York, U.S.A.

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Alberta: (1) Miss Ida Johnson, Royal Alexandra Hospital, Edmonton; (2) Miss B. J. von Gruenigen, Calgary General Hospital; (3) Miss R. E. McClure, Clover Bar Health Unit, Qu'Appelle Bldg., Edmonton; (4) Miss N. Sewallis, 9918-108th St., Edmonton.

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Prince Edward Island: (1) Miss K. MacLennan, Provincial Sanatorium, Charlottetown; (2) Mrs. Lois MacDonald, Prince Co. Hospital, Summerside; (3) Mrs. C. H. Beer, 277 Kent St., Charlottetown; (4) Miss Mildred Thompson, 20 Euston St., Charlottetown.

Quebec: (1) Miss Eileen Flanagan, 3801 University St., Montreal; (2) Miss Winnifred MacLean, Royal Victoria Hospital, Montreal; (3) Miss Ethel B. Cooke, 830 Richmond Sq., Montreal; (4) Mlle Anne-Marie Robert, 6716 rue Drolet, Montreal.

Saskatchewan: (1) Miss M. R. Diederichs, Grey Nuns' Hospital, Regina; (2) Miss Ethel James, Saskatoon City Hospital; (3) Miss Mary E. Brown, 5 Bellevue Annex, Regina; (4) Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon.

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For those who eat and run...

A bite, a gulp and he's off. But that's no meal for an active person. A hurried breakfast or a hurried lunch does not tend to provide all the food nutrients which everyone needs—especially today. "Alphamin" taken daily will help to adjust this all too common dietary state.

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"ALPHAMIN"

A biologically-standardized product of essential vitamins (A, B, C and D) and minerals (iron and calcium).

Supplied in boxes of 25 and 50 doses.

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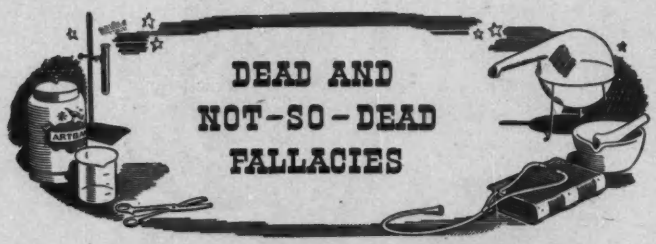

CURE FOR RABIES: a mixture of powdered canine jawbone, the ground-up false tongue of a newly foaled colt, and green rust scraped from surface of English penny, reign of George I. Pasteur killed that fallacy and many other rabies "cures" in 1885.

THE DARKNESS inside a food can causes the vitamins in the food to deteriorate. On the contrary, darkness tends to preserve the vitamins. Yet, statements like this one are repeated impressively by the "food-fad" layman. You may have even been consulted by some.

As much nutritional research on canned foods has shown, all vitamins are retained to a high degree either in the processed food itself or in the liquid in which the foods were cooked.

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AMERICAN CAN COMPANY, HAMILTON, ONTARIO;
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When a patient seeks advice on the

ADEQUACY

OF INTERNAL MENSTRUAL PROTECTION...

Both in independent laboratory tests and in careful clinical studies, Tampax tampons have been shown to possess a wide margin of safety in providing for intravaginal absorption of the flux.

Though variations, of course, occur in the amount of blood lost during the period—most women have been found to conform within relatively narrow departures from the average of 50 cc.[1].

Even *Junior Tampax* provides amply adequate protection—with its absorptive capacity of 20 cc. for *each tampon*, or 200 cc. for the period (10 tampons are usually considered an ordinary month's supply). In addition, *Regular Tampax* has a capacity of 30 cc., and *Super Tampax* 45 cc. for *each tampon* (or 300-450 cc. for the period).

In a recent study[2] of 110 young nurses employing Tampax tampons for catamenial protection, it was found that "95 per cent used tampons with satisfaction all through menstruation."

In another series[3], 18 (or 90%) of 21 subjects had "complete protection". Also "complete protection was afforded in 68 (94%) of 72 periods reported."

Other clinicians[4], investigating "twenty-five women under close institutional observation", noted that "with a tampon of proper size, absolute comfort and complete control of the flow can be obtained . . . the obvious advantage of the small, medium and large sized tampon of the particular brand (Tampax) is to be noted."

The results of this research parallel the experience of thousands of women who have found that Tampax affords thoroughly adequate protection

(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

TAMPAX *accepted for advertising by the Journal of the American Medical Association*

Canadian Tampax Corporation Ltd., Brampton, Ont.

Please send me a professional supply of the three absorbencies of Tampax.

P4-24

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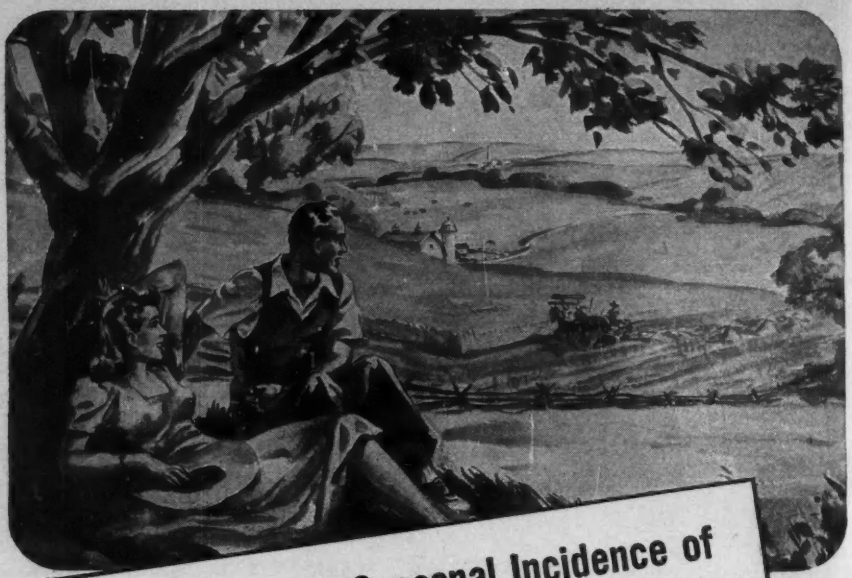

In the Greater Seasonal Incidence of PRURITIC AFFECTIONS

With the coming of warmer weather, the occurrence of pruritic skin affections rises sharply. Contact with poisonous plants, food allergies, and toxic insects, all contribute to this greater incidence. While days or weeks may be required to eradicate these dermatoses, relief from the intense, furious itching need not be denied the patient. Prompt application of Calmitol allays all discomfort for several hours, regardless of the nature of the offending toxin or allergen. Calmitol is equally effective against the itching of food and drug poisonings, urticaria, eczema, intertrigo, prurigo, ringworm, and against pruritus ani, vulvae, and scroti.

The anti-pruritic properties of Calmitol are due to the valuable pharmacodynamic influence of its ingredients: camphorated chloral, menthol, and hyoscyamine oleate, in an alcohol-chloroform-ether vehicle. A three-fold action is exerted: (1) Sensory impulses are blocked at the afferent nerve endings and cutaneous receptor organs; (2) local active hyperemia encourages resolution of the underlying process; (3) bacteriostasis aids in preventing spread. Calmitol Ointment is thoroughly bland and may be applied safely to the skin of infants. * * * Professional samples available on request.

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CALMITOL

THE DEPENDABLE ANTI-PRURITIC

"When I feel like this, I'm glad I'm a nurse!"

"Like anyone else, I've my share of 'off days'.

"But I've noticed that the Doctor often gives patients Anacin to relieve pain. And I've seen how quickly and effectively these tablets work.

"So when *I* have a simple headache or pain—especially the 'periodic' kind—I tell myself I'm lucky because I know just what to do. I take Anacin. And it always brings me quick relief."

Anacin is compounded of ingredients that give a greater analgesic effect for relief of pain associated with simple headaches, minor neuralgia and regular menstrual periods.

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An all wool cape, with a capuchin.

Very smart

Very cosy

Deliveries on capes in 2 weeks.

We know our deliveries are discouragingly slow. They will probably remain this way until the end of the year. So please—

"Praise us for our virtues and blame us for our faults".

BUT TRY AND FORGIVE US FOR BEING SO TARDY WITH THE SHIPMENT OF YOUR ORDERS.

There have been conditions existing over which we have no control.

Nurses TAILORED Uniforms Only

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BULLETINS SUMMARIZING KILLIAN LABORATORIES REPORT ON BABY FOODS

COMBINING SEVERAL VEGETABLES IN CANNED BABY FOODS INCREASES NUTRITIVE VALUES

Libby's *Homogenized Baby Foods are canned in combinations of three or more vegetables and fruits so that nutritional values of one or two foods compensate for the dietetic deficiencies of other foods included in the combination.

Killian Laboratories, reporting on a series of researches, have released findings indicating that these foods:

(1) possess substantial fuel values as well as being good or excellent sources of Vitamins A and C and of iron.

(2) increase significantly the biological value of the iron content above the level of the vegetable which, in the combination, has the maximum iron content.

(3) augment the caloric as well as the biological value of the total iron.

A series of bulletins descriptive of the Killian studies on baby foods is available to pediatricians and physicians on application to Libby, McNeill & Libby of Canada, Limited, Chatham, Ontario.

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Chatham, Ontario

8 BALANCED BABY FOOD COMBINATIONS:

These combinations of Homogenized Vegetables, cereal, soup and fruits make it easy for the Doctor to prescribe a variety of solid foods for infants:

1. Peas, beets, asparagus.
2. Pumpkin, tomatoes, green beans.
3. Peas, carrots, spinach.
4. Whole milk, whole wheat, soya bean flour.
6. Soup—carrots, celery, tomatoes, chicken livers, barley, onions.
7. A meatless soup-consisting of celery, potatoes, peas, carrots, tomatoes, soya flour, and barley. Can be fed to very young babies.
9. An "all green" vegetable combination—Many doctors have asked for this. Peas, spinach and green beans are blended to give a very desirable vegetable product.
10. Tomatoes, carrots and peas — these give a new vegetable combination of exceptionally good dietetic properties and flavour.

And in addition, Two Single Vegetable Products Specially Homogenized:

PEAS, SPINACH AND LIBBY'S HOMOGENIZED EVAPORATED MILK

Libby's HOMOGENIZED BABY FOODS

***Libby's are the Only Baby Foods that are Homogenized.**